



“FLEEING MY WHOLE LIFE”

OLDER PEOPLE’S EXPERIENCE OF CONFLICT AND
DISPLACEMENT IN MYANMAR

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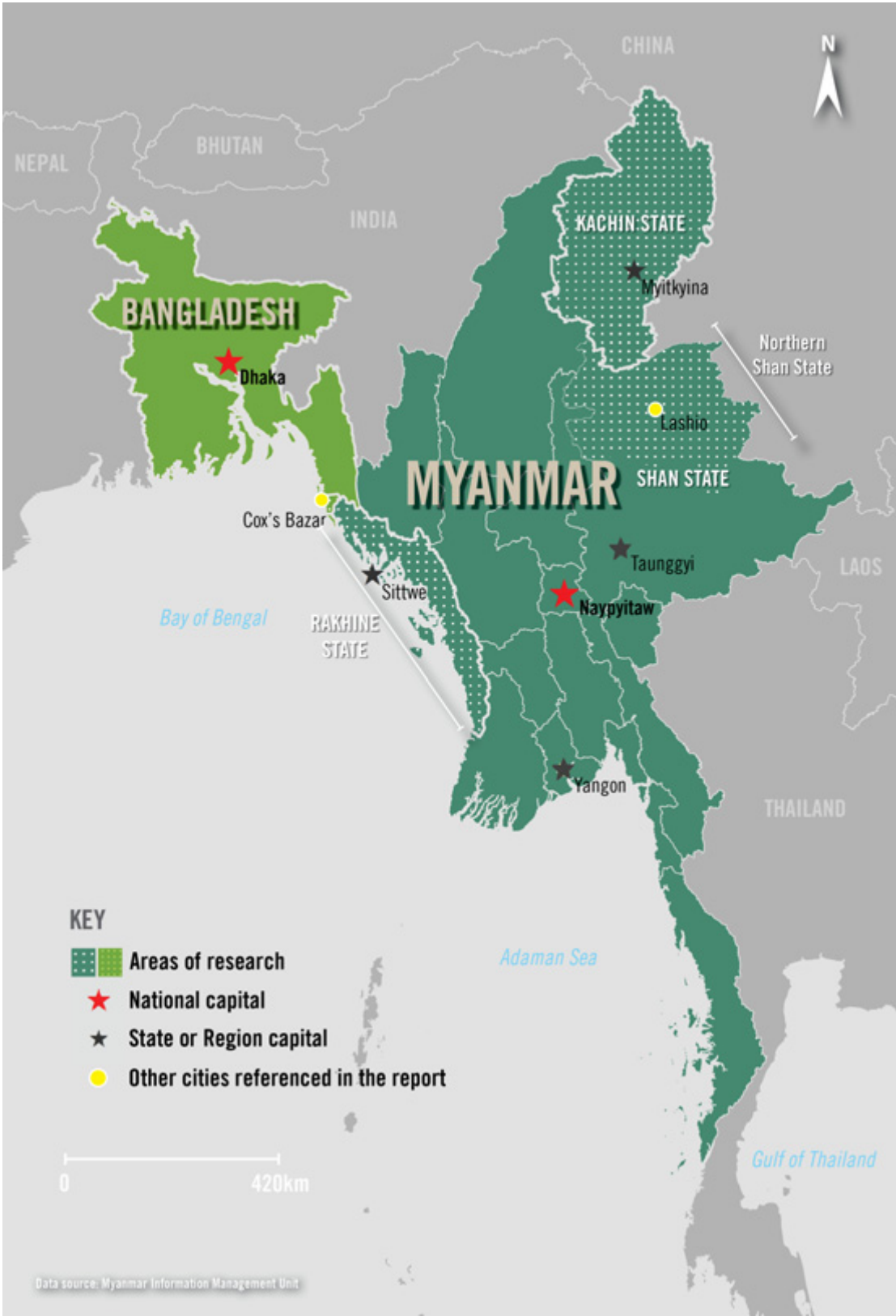
Cover photo: An older Rohingya man walks up steps toward a latrine in a refugee camp in Bangladesh. Camp infrastructure has developed significantly in the 21 months since the Myanmar military's campaign of violence forced more than 740,000 Rohingya to flee to Bangladesh, but basic services remain inaccessible to many older people, amid the camps' hilly terrain, 18 February 2019.
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MAP



GLOSSARY

WORD	DESCRIPTION
AA	Arakan Army, a primarily ethnic Rakhine armed group. Historically headquartered and trained in KIO-controlled areas of Kachin State, it has moved significant parts of its fighting force down to Rakhine State in recent years
CESCR	Committee on Economic, Social, and Cultural Rights, the UN expert body that monitors the implementation of the ICESCR
CRPD	Convention on the Rights of Persons with Disabilities
ICESCR	International Covenant on Economic, Social, and Cultural Rights
IED	Improvised Explosive Device, typically a landmine-like or bomb-like weapon
IDP	Internally Displaced Person
IOM	International Organization for Migration
KIO/A	Kachin Independence Organization/Army, the political and military wings of an ethnic armed group that controls a thin area of territory in Kachin State, primarily along the China border. It also operates in northern Shan State
NGCA	Non-government-controlled areas, or territory of Myanmar controlled by ethnic armed organizations, including parts of Kachin State along the China border
Northern Myanmar	A term used in this report to signify Kachin and northern Shan States
SGBV	Sexual and gender-based violence
Tatmadaw	The official Burmese name of the Myanmar Armed Forces
TNLA	Ta'ang National Liberation Army, the armed wing of the Palaung State Liberation Front, an ethnic armed organization in northern Shan State
UNHCR	UN Refugee Agency
Village Tract	An administrative subdivision in rural areas of Myanmar, comprising a collection of villages
WASH	Water, sanitation, and hygiene programs, part of humanitarian response

EXECUTIVE SUMMARY

“I’ve been fleeing my whole life—as a child; as a mom, carrying my child on my back... It’s been a difficult life.”

A 71-year-old ethnic Kachin woman displaced repeatedly throughout her life by conflict and military abuses and who, when interviewed by Amnesty International on 11 December 2018, had been living for more than seven years in a camp for internally displaced persons in Waingmaw Township, Kachin State, Myanmar.

“It’s of course good that we’re safe. But there is so much emotional and psychological stress for us here. Sometimes it feels like a small corner of hell... We can’t go on like this.”

Kobir Ahmed, 63, an ethnic Rohingya refugee from Maungdaw Township in Rakhine State, Myanmar, currently living in Camp #15 in Bangladesh, where he was interviewed by Amnesty International on 15 February 2019.

Older people are largely invisible in situations of crisis, including during armed conflict and in humanitarian response. Their rights are often not respected, their needs unmet. In Myanmar, older people from many ethnic minorities have endured a lifetime of conflict, displacement, and military abuse. Now, in older age, military operations have again forced them out of their home and village, often where they have lived for decades, and into a displacement setting where they face distinct hardships that are frequently overlooked.

This report examines the impact of conflict and displacement on older people in areas of Myanmar where the military has undertaken recent operations—operations marred by crimes under international law, as Amnesty International has reported previously. It looks at the specific ways older people are affected by conflict, both in the violations they suffer and the psychosocial impact. There are tens of thousands of older people among the more than one million people displaced within Myanmar or to neighbouring Bangladesh. This report also analyses how and why humanitarian assistance is falling short in responding to their needs.

Amnesty International undertook three research missions between December 2018 and April 2019 with a focus on older people, including to Kachin and northern Shan States in northern Myanmar; to Rakhine State, in western Myanmar; and to the Rohingya refugee camps in Bangladesh. In total, Amnesty International interviewed 146 older women and men, as well as at least two dozen people who witnessed the death of an older person during Myanmar military operations. Interviewees were from the ethnic Kachin, Lisu, Rakhine, Rohingya, Shan, and Ta’ang communities; at the time of the interview, the overwhelming majority were displaced from their home to refugee camps in Bangladesh, to internally displaced person (IDP) camps in northern Myanmar, or to makeshift displacement sites. This report also draws from interviews with international and local humanitarian workers in Bangladesh and Myanmar, as well as from written responses that the Bangladesh offices of the UN Refugee Agency (UNHCR) and the International Organization for Migration (IOM) provided to questions that Amnesty International sent at the conclusion of its research.

There is no global definition in international law of what constitutes an “older person”. It has often been defined as age 60 or older, though the Office of the High Commissioner for Human Rights (OHCHR) has

promoted a context-specific approach, which Amnesty International agrees responds better to individual rights and needs than an arbitrary minimum cut-off. In the Myanmar context, Amnesty International has included some people in their 50s, also taking into account their self-identification as an “older person”.

Older people, like individuals of all social identities, are not homogenous. Many older women and men in the rural borderlands of Myanmar, where most of the country’s conflicts and recent military operations have occurred, provide entirely for their own livelihood and well-being; they farm their fields or fish in nearby creeks, sell goods at market, and support children who remain at home. Other older women and men are housebound, with physical disabilities that require assistance to move around and to eat. In between, there is a spectrum of experience and needs. Governments and humanitarian organizations need to work together to respect and fulfil everyone’s individual rights; that requires identifying and responding to risks associated with older age, including related to mobility, disability, nutrition, and certain health conditions.

CONFLICT AND ABUSE

When the Myanmar military undertakes operations against armed groups, older people are not spared its crimes. Soldiers have shot and killed older women and men who were fleeing; fired mortar and artillery shells indiscriminately that explode near older people, killing or injuring them and damaging their homes; and have arbitrarily detained older people and subjected them to torture or other forms of ill-treatment as punishment or to extract information about an armed group. Some older women are survivors of sexual violence committed by members of the security forces, and some older men are survivors of sexualized torture. For some of these patterns of military abuse, older people are at times at less risk than younger women and men—particularly men considered to be of fighting age—but, in many instances, no distinction is made.

In other respects, older women and men in conflict-affected areas of Myanmar face heightened risks. Older people often remain behind when other villagers flee a military advance, either due to limited mobility or a deep connection to their home and land. When soldiers discover older people who stayed behind, they at times murder them or subject them to torture or other ill-treatment. A 67-year-old ethnic Rakhine farmer who stayed at home when most of his village fled in March 2019, in part because a severe hearing impairment meant he had not heard fighting nearby between the military and Arakan Army (AA), described being beaten and then tied to a post for hours, as Myanmar soldiers questioned him about the AA. Mariam Khatun, around 50 years old, had to leave her parents, both of who had severe physical disabilities that left them unable to walk, when Myanmar soldiers attacked her Rohingya village in August 2017; as she looked back while fleeing, she saw the village burning, knowing her parents were still inside the home.

Many older people also face particular risks of illness, injury, and death when fleeing in Myanmar’s mountainous borderlands, worsened by the military closing off or erecting checkpoints on main routes. Due to the risks of remaining behind and the risks associated with fleeing, older people appear, at least in certain contexts, to suffer disproportionately. Based on rigorous quantitative surveys carried out in the refugee camps in Bangladesh, Médecins Sans Frontières (MSF) estimated that, during the military’s attack on the Rohingya population in the month after 25 August 2017, the highest rates of mortality—by far—were among women and men age 50 and older, with violence the direct cause of death in the large majority of cases.

Older women and men in Myanmar have suffered both acutely and cumulatively. The psychosocial impact of being exiled from their home and land is often profound. Many older women and men, especially among the ethnic Kachin and Rohingya communities, have been displaced repeatedly since their childhood, causing a lifetime of instability and feelings of guilt about being unable to provide for their family or to put children through school. *“It’s been really difficult, we had to start all over again and again,”* said a 62-year-old ethnic Kachin woman. *“When we built up [our lives], then we fled again. When I think about it, I want to cry.”*

Some older people have also experienced the murder or rape of their children; in many instances, they witnessed the crime. Yet despite the specific types of trauma or distress that older women and men face, there is almost no psychosocial support aimed at them, including in refugee and IDP camp settings.

In response to the Myanmar military’s crimes, several accountability efforts are underway, including a preliminary examination by the Office of the Prosecutor of the International Criminal Court (ICC) into Myanmar’s deportation of the Rohingya population to Bangladesh; and an Independent Investigative Mechanism for Myanmar (IIMM), established in September 2018 by the UN Human Rights Council to collect and preserve evidence of crimes committed across Myanmar since 2011 and to build criminal cases. During their investigations, these bodies should seek out older women and men, given their specific experience of recent crimes and unique perspective on the persecution that underlies those crimes.

FORCED DISPLACEMENT, HUMANITARIAN RESPONSE

The scale of the Myanmar military’s atrocities, and the displacement they have caused over the last eight years, has put an enormous burden on UN agencies and humanitarian organizations—made all the more

difficult by the severe access restrictions the Myanmar authorities have imposed. In many ways, the humanitarian response has been impressive, both in the refugee camps in Bangladesh and for people displaced internally in Myanmar. The humanitarian community has built and improved camp infrastructure; delivered life-saving assistance amid challenging environments; and met most people's basic needs.

Older women and men, however, have often fallen through the cracks, resulting in their rights not being respected. The problems start with identification: Humanitarian organizations have inadequately collected, analysed, and disseminated age-, sex-, and disability-disaggregated data. The lack of age-disaggregated data, and the related under-inclusion of older people in data collection itself, undermines a more nuanced understanding of experiences and risks at different ages. The failure to disaggregate data adequately on other grounds, alongside age, undermines an understanding of how aging intersects with other social identities, including gender and disability—the latter of which the World Health Organization has estimated to impact almost 60 percent of older people in low- and middle income countries of Southeast Asia.

The lack of identification and analysis undermines a humanitarian response's effectiveness. It misses risks faced by older people with limited mobility or who are shelter-bound in a camp. Humanitarian assistance also too often appears rooted in an assumption that all older people live with and are supported by other family members. While true for some older people, Amnesty International interviewed many who were living alone; their isolation, especially when combined with disability or limited mobility, puts them at particular risk. Other older people are the head of a household—including as primary caregivers for grandchildren whose parents were killed by the military. A more nuanced understanding of the experiences and situations of older persons, including the harms they have suffered, is essential to better respond to their needs.

OLDER PEOPLE IN THE BANGLADESH REFUGEE CAMPS

In the Bangladesh refugee camps, tens of thousands of older Rohingya women and men are among the more than 910,000 people forced to flee successive campaigns of violence by the Myanmar security forces. In the most fundamental aspects of humanitarian assistance—shelter, food, water, sanitation, and health care—the response in Bangladesh is not respecting older people's rights, nor meeting humanitarian principles of a right to life with dignity and of inclusivity and non-discrimination.

Among older Rohingya women and men in the camps, the lack of access to a latrine is one of the most commonly cited problems. The distance to and difficult-to-reach location of latrines amid the camps' hilly terrain has made them largely inaccessible, forcing many older refugees, including those with moderate mobility, to use a pan inside their shelter. There has been insufficient attention to the rights and needs of older people, for example by ensuring their shelters are in flatter areas that make latrines and other camp services most accessible and by selecting locations for new latrines with a mindfulness to people with limited mobility. The lack of lighting in the camps makes accessing a latrine even more difficult at night.

"I go to the latrine here, I eat and sleep here," said Mawlawi Harun, a Rohingya refugee in his early 90s, while sitting in his shelter. "I have become like a cow or goat. What more can I say? Cows defecate and urinate in the same place where they eat... Now I'm sleeping in a latrine."

Camp health services are likewise failing to respect older people's rights to health and dignity. The health response remains overwhelmingly centre-based, with people having to get to a camp clinic to see a health professional and receive treatment. There are a few mobile medical clinics, and further plans to develop mobile clinics, but even these are primarily mobile from camp to camp, rather than shelter to shelter. Among the older refugees interviewed by Amnesty International who had limited mobility or were shelter-bound, almost none of them had been seen or treated by a health professional in their shelter or assisted by a health provider in getting to a clinic. For the many older women and men who cannot access camp clinics due to the distance or the camps' terrain, the situation does not respond to their needs.

Even when older people can physically access camp clinics, some of those clinics are unable to provide medication for common chronic conditions, such as high blood pressure, chronic pain, and chronic respiratory disease, which disproportionately affect older people. Due to camp clinics' inaccessibility and uneven quality, a majority of the older people interviewed by Amnesty International said that, even when living with a chronic condition, they do not go to them regularly, or, for some people, ever. Instead, they need to buy from camp markets medication that should be provided free of charge as part of the humanitarian response. Many older people are unable to afford such medication, or at least to do so regularly. Others are forced to sell part of their food ration or other items—negatively impacting their health in other ways.

Most older Rohingya refugees are surviving on lentils, rice, and oil; the lack of diet diversity poses particular risks to their health and well-being. Food distribution centres, water points, and cooking material remain difficult, if not impossible, for many older people to reach, without adequate alternatives available. The burden of finding water and cooking material falls largely on women, including older women. Compounding

the problems, the humanitarian response has often inadequately informed, much less consulted with, refugees about changes to the food distribution or about how to resolve problems like a family member not being included on a distribution list, which appears to have a disparate impact on older women and men.

The humanitarian response is becoming more inclusive; UNHCR and IOM both cited ongoing and planned initiatives that will improve access to services for many people, including some older people. But much of this should have happened sooner—and should happen sooner in future humanitarian emergencies. And more still needs to be done by the Bangladesh government and humanitarian community, beyond the current initiatives and plans. Shelter and latrine construction and rehabilitation, as well as upgrades to camp pathways, need to be done with far more attention to accessibility for older people, and in particular older people with limited mobility; where not possible in their current shelter, older people should be consulted, in accordance with their needs and preferences, about possible relocation to improve access to camp services.

The health response needs to become far more mobile, including the provision of in-shelter care for people with limited mobility or who are shelter-bound, or, when not possible, assistance or transport vouchers to reach camp clinics. Camp clinics should be required to stock medication for common chronic diseases, such as high blood pressure, diabetes, and chronic respiratory illness. And older people should be included in psychosocial care programs and activities, with attention to the specific harm they have experienced.

More generally, community outreach networks should be expanded and better trained to assist older people, and in particular older people with limited mobility or who are living alone, with collecting distributions; obtaining adequate drinking water; communicating changes to assistance; and answering questions about how to resolve problems. Older people should also be far better included in humanitarian programme design and implementation, including as community outreach members and volunteers themselves.

For their part, donor governments should, in addition to increasing assistance to respond to the general needs that exist, include explicit provisions on inclusivity and non-discrimination in any assistance or grants and monitor the work of implementing partners to ensure those principles are upheld. They should also strongly consider funding supplemental cash assistance to older people and others with particular risks and needs, as part of the new e-voucher system in the refugee camps led by the World Food Programme (WFP).

OLDER PEOPLE DISPLACED IN MYANMAR

In northern Myanmar, more than 105,000 people from ethnic minorities live in IDP camps, many of which have existed for close to a decade; at any one time, depending on where fighting is most intense, thousands more people live in makeshift sites while displaced for shorter periods. In Rakhine State, the fighting between the Myanmar military and the AA has displaced at least 30,000 more people since late 2018.

During shorter-term displacements, older women and men face disruptions in their access to essential medication and to their normal source of livelihood, which has secondary effects on their rights to food and health. Pya Pa Mei, a 65-year-old Lisu woman displaced in March 2019 from her village to a makeshift site in northern Shan State, said she needed to take medication daily for her diabetes; she had only two days' supply left when interviewed by Amnesty International and no clear way to obtain more, as her displacement meant she had been unable to earn money clearing people's farms or collecting and selling corn.

During longer-term displacement to IDP camps, older people describe discrimination in accessing work. *"I've approached the employers and said I want to work,"* said Zatan Hkawng Nyo, a 67-year-old ethnic Kachin woman who spent a lifetime farming before being displaced to an IDP camp. *"They said I'm too old, that I won't be able to walk that far to [the paddy fields]... No one invites us older people [to work]."*

Some humanitarian programs, particularly those aimed at livelihood support, appear to discriminate against, or at least under-include, older people. Older people in general, and older women in particular, also tend to be under-represented in camp leadership positions, denying them a voice and role in decision-making.

Donor governments and humanitarian organizations responding to displaced people in Myanmar need to better ensure that all programs, including livelihood assistance, are inclusive and do not discriminate against older people and people with disabilities. The Government of Myanmar should work with the humanitarian community to better respond to displaced older people's needs, including in the provision of health services.

In recent years, governments, UN agencies, and humanitarian organizations around the world have committed to better meet the rights and needs of underserved and underrepresented groups, including older people. Standards have been developed, including the Sphere Standards and the *Humanitarian inclusion standards for older people and people with disabilities*, which focus on how humanitarian principles of inclusivity, non-discrimination, and the right to life with dignity should be applied to respect the rights of older people. Despite the growing understanding and notable commitments, the situation of older people in conflict-affected areas of Myanmar and in the Bangladesh refugee camps shows much progress is needed.

METHODOLOGY

This report is based primarily on field and remote research undertaken between November 2018 and May 2019. Amnesty International delegates undertook three research missions that focused on the experience of older women and men in conflict- or crisis-affected areas of Myanmar,¹ including a one-week mission to government-controlled areas of Kachin State, Myanmar in December 2018, to interview older people living in internally displaced person (IDP) camps; a two-week mission to the Cox's Bazar district of Bangladesh in February 2019, to interview older people living in refugee camps; and a two-week mission to Myanmar in March and April 2019, which included, among other areas of research focus, interviews with older people living in conflict-affected areas of northern Shan State and of Rakhine State.

The research missions with a focus on older people built on recent Amnesty International research on human rights violations and abuses, including crimes under international law, committed during Myanmar military operations in Kachin, Rakhine, and Shan States. During that research, which has included multiple missions to northern Myanmar and to Bangladesh since 2017, delegates interviewed older women and men who were victims or direct witnesses to violations; older Rohingya women and men who spoke about the situation in the Bangladesh refugee camps; and older Kachin women and men who spoke about the situation in IDP camps in government- and non-government controlled areas. All of those interviews also inform this report's findings, analysis, and recommendations, though particular weight is given to the more recent research that has been done specifically to examine the experience and needs of older people.

In total, Amnesty International interviewed 146 older women and men from ethnic minorities in conflict- or crisis-affected areas of Myanmar. This includes 39 older Rohingya women and 50 older Rohingya men from at least 15 of the 34 refugee camps in Bangladesh;² 16 older Kachin women and 18 older Kachin men, 27 of who lived in IDP camps in northern Myanmar at the time of the interview; two older Rakhine women and six older Rakhine men affected by fighting between the military and Arakan Army in Rakhine State; and four older Shan women and four older Shan men, four older Ta'ang women and one older Ta'ang man, and two older Lisu women, all affected by the ongoing armed conflicts in northern Shan State.

Along with seeking out interviews with both older women and older men, and with older people from different ethnic minorities, Amnesty International sought to obtain a diverse group of interviewees on other issues, including: the person's level of mobility; whether a person had one or more physical disabilities; and different age ranges within older age. Amnesty International interviewed 34 people between 54 and 59 years old who self-identified as an older person;³ 62 people between 60 and 69 years old; 27 people between 70 and 79 years old; 11 people between 80 and 89 years old; and 12 people who were age 90 or older.

In addition to interviews with older people themselves, Amnesty International interviewed at least two dozen people, primarily Rohingya women and men, who were witnesses to the death of older people as a result of Myanmar military operations. Amnesty International also interviewed representatives of international and local humanitarian organizations operating in Bangladesh and Myanmar, including humanitarian actors

¹ Amnesty International does not consider the situation between the Myanmar military and the Rohingya armed group known as the Arakan Rohingya Salvation Army (ARSA) to have risen to the level of an internal armed conflict and therefore does not use the language of armed conflict or an analysis of international humanitarian law in that context. It does consider the other situations discussed in this report—including in Kachin and northern Shan States, and in Rakhine State between the military and Arakan Army—to be internal armed conflicts.

² During Amnesty International's research in February 2019, delegates interviewed older refugees living in 15 different camps. Additional interviews with older women and men were conducted in September 2017 and January 2018, before the division into 34 camps happened; some of those people likely live in areas outside the 15 camps covered in February 2019.

³ Including them as "older people" for the purposes of this report is also appropriate when taking into consideration the context. According to the World Health Organization (WHO), the average life expectancy in Myanmar is around 65 years for men and 69 years for women. See WHO, Myanmar, <https://www.who.int/countries/mmr/en/>. And the people on which this report focuses have experienced decades of conflict, displacement, and oppression.

involved in protection; health; and water, sanitation, and hygiene (WASH), as well as actors specializing in humanitarian response to older people and to people with disabilities. Additional in-person and telephone interviews were carried out with donors funding humanitarian assistance in Bangladesh; and with experts on the rights of older people in humanitarian situations.

Amnesty International informed interviewees about the nature and purpose of the research and about how the information provided would be used. Oral consent was obtained from each person prior to the start of the interview. People were told that they could end the interview at any time and that they could choose not to answer specific questions. In the course of this research, several interviewees did end interviews, because they said they were tired or, in one instance, needed to get to a camp clinic before it closed.

No incentives were provided to interviewees in exchange for their accounts. Amnesty International reimbursed transport and accommodation costs when interviewees had to travel to meet with delegates.

Amnesty International has included the names of certain individuals who were interviewed, based on their informed consent. Other people spoke on condition of anonymity, generally due to concerns that they might face reprisals from the Myanmar authorities, and in particular the security forces, should it become known that they spoke with Amnesty International. Information that could identify these interviewees, including the village they are from, the place where they were interviewed, the date an incident occurred, and their occupation, has often been withheld to protect their security and privacy.

People's ages noted in this report are based on information provided by the interviewee. For the Rohingya population in particular, referenced ages are often approximations, in large part because the Myanmar authorities have systematically denied them access to education and have created obstacles to registering new births.⁴ In addition to asking an interviewee how old she or he was, Amnesty International delegates asked older Rohingya women and men questions about their age at major historical markers (e.g., the Second World War and the violent expulsion in 1978), to better inform an estimate of the person's current age. When there is uncertainty, the report uses the word "around" before providing an estimated age.

Villages in ethnic minority areas of Myanmar typically have several names: an official name and the name or names used by one or more ethnic minorities living there. Each name is, in turn, often anglicized in different ways. To maintain consistency and to simplify identification, Amnesty International has tried, throughout this report, to identify villages, village tracts, and townships based on the spelling used by the UN Myanmar Information Management Unit (MIMU).

Unless otherwise indicated, conversion from Bangladesh taka (BDT) and Myanmar kyats (MMK) to US dollars reflects online exchange rates from 15 April 2019, when US\$1 equalled 84.32 BDT and 1,518 MMK. Except for very small amounts, converted figures are rounded to the nearest whole number.

On 17 May, Amnesty International sent letters to the Bangladesh offices of the UN Refugee Agency (UNHCR) and of the International Organization for Migration (IOM), presenting the main findings related to the situation of older women and men in the refugee camps in Bangladesh and asking questions about the humanitarian response. IOM and UNHCR replied on 30 and 31 May, respectively. Amnesty International has incorporated some answers into the report and included the full written responses in Annexes. Amnesty International extends its appreciation to both agencies for providing detailed responses, and for the willingness to engage with the organization's findings and concerns.

Amnesty International has previously written to Myanmar's civilian and military leadership about the organization's investigations into the military's crimes under international law and other human rights violations against the Rohingya population from August 2017 and as part of the operations in Rakhine State against the Arakan Army in 2019. Neither the civilian nor military authorities have responded.

⁴ Amnesty International, *"Caged without a Roof": Apartheid in Myanmar's Rakhine State* (Index: ASA 16/7484/2017), 21 November 2017.

1. BACKGROUND

1.1 DECADES OF CONFLICT AND ABUSE IN THE BORDERLANDS

In the 71 years since Myanmar's independence, the country's borderland regions, populated mostly by ethnic minorities, have lived through protracted internal armed conflicts. For many older women and men in these areas, displacement and abuse—primarily at the hands of the Myanmar military, though also, at times, by ethnic armed groups—have impacted every part of their life.

Political and ethnic tensions in the borderlands date back to the period of British rule, which governed separately the central plains, referred to as “Ministerial Burma,” largely inhabited by ethnic Burman, who comprise more than 65 percent of the country's population; and the surrounding mountainous regions, referred to as “Frontier Areas”.⁵ Months after independence in January 1948, armed groups launched uprisings in several parts of country; some sought complete independence, while others fought for greater rights and autonomy within a more federal system of government.⁶

This report focuses on the experience of older people in two parts of the country: Kachin and northern Shan States, in northern Myanmar, on the country's long border with China; and Rakhine State, in western Myanmar, which borders Bangladesh. Amnesty International has published recent reports on the crises in each of those regions, with detailed examinations of their history and context; this section will provide only a brief overview.⁷ Older people in several regions of the country not examined in this report, including Kayah, Kayin, and Chin States, have experienced similar patterns of conflict and abuse during their lifetimes.⁸

In northern Myanmar, conflict between the military and ethnic armed groups began in the early 1960s. Believing the government was no longer looking after their interests, Kachin nationalists formed the Kachin Independence Army (KIA) and took up arms in 1961. The next year, the Myanmar military, known as the Tatmadaw, carried out a coup, after which it consolidated power within a military-controlled central government, banned opposition political parties, and cracked down on civil liberties.⁹ In subsequent years, insurgencies proliferated, including in northern Shan State, where the Communist Party of Burma, consisting of troops from several ethnic groups, enjoyed financial and military backing from its counterparts in China.¹⁰

After several more decades of fighting, the Myanmar military signed ceasefire agreements between 1989 and 1994 with each of the major ethnic armed groups in northern Myanmar, including, in February 1994,

⁵ International Crisis Group, *Myanmar: A New Peace Initiative*, Asia Report No. 214, 20 November 2011, p. 1. For more information on the ethnic composition of Myanmar, see Reuters, “Factbox: Key facts about Myanmar,” 18 November 2011; Lex Rieffel, “Peace in Myanmar depends on settling centuries-old ethnic conflicts,” Brookings Institute, 20 March 2017.

⁶ See International Crisis Group, *Myanmar: A New Peace Initiative*, p. 2; Human Rights Watch, “*Untold Miseries: Wartime Abuses and Forced Displacement in Burma's Kachin State*,” pp. 22-23.

⁷ See Amnesty International, “*All the Civilians Suffer: Conflict, Displacement and Abuse in Northern Myanmar* (Index: ASA 16/6429/2017), 14 June 2017; Amnesty International, “*Caged without a Roof*”; Amnesty International, “*We Will Destroy Everything: Military Responsibility for Crimes against Humanity in Rakhine State* (Index: ASA 16/8630/2018), 27 June 2018.

⁸ See, for example, Amnesty International, *Crimes against Humanity in Eastern Myanmar* (Index: ASA 16/011/2008), 5 June 2008; Amnesty International, *Leaving Home* (Index: ASA 16/023/2005), 7 September 2005; Amnesty International, “*No Place to Hide: Killings, Abductions and Other Abuses against Ethnic Karen Villagers and Refugees* (Index: ASA 16/013/1995), 5 June 1995; Harvard Law School International Human Rights Clinic, *Policy Memorandum: Preventing Indiscriminate Attacks and Willful Killings of Civilians by the Myanmar Military*, March 2014; Richard Sollom et al., “Health and Human Rights in Chin State, Western Burma: A Population-Based Assessment Using Multistaged Household Cluster Sampling,” *PLoS Med* Vol. 8(2), 2011, <https://doi.org/10.1371/journal.pmed.1001007>; Human Rights Watch, “*We Are Like Forgotten People: The Chin People of Burma: Unsafe in Burma, Unprotected in India*, January 2009.

⁹ See International Crisis Group, *Myanmar: A New Peace Initiative*, p. 2.

¹⁰ See International Crisis Group, *Myanmar: A New Peace Initiative*, p. 2.

with the KIA.¹¹ That ceasefire lasted 17 years, before breaking in June 2011. Eight years later, northern Myanmar remains engulfed in fighting, both between the military and ethnic armed groups, and, particularly in northern Shan State, between different ethnic armed groups. A four-month unilateral ceasefire declared by the military in December 2018, and renewed for two more months on 30 April 2019,¹² has led to a reduction in fighting between the military and the KIA in Kachin State, but regular clashes continue in northern Shan State, resulting in the displacement of more than 11,000 people in the first quarter of 2019.¹³

In Rakhine State, the Myanmar authorities have long persecuted the predominantly Muslim Rohingya population. Older women and men interviewed for this report described family ties to specific villages dating to the 1800s and earlier; and showed land documents from the British period, as well as nationality documents from the first years of Myanmar's independence.¹⁴ Yet successive governments have denied that the Rohingya are an ethnic group from Myanmar, asserting they are migrants from Bangladesh who settled in Myanmar "illegally". Most Rohingya are not recognized as citizens, as the Myanmar authorities have used a range of laws, policies, and practices—most notably the 1982 Citizenship Law—to deprive them of their right to a nationality. The overwhelming majority of Rohingya living in Rakhine State, as well as those who fled recently to Bangladesh and other states, have no reasonable claim to citizenship other than in Myanmar.

The Myanmar authorities have used the lack of citizenship to severely restrict the Rohingya population's freedom of movement and to severely limit their access to healthcare, education, and work opportunities. The persecution became particularly pronounced in the aftermath of violence in 2012 between the Rohingya and ethnic Rakhine, the latter of who were at times supported by the security forces. Amnesty International has concluded that the discriminatory and dehumanising regime, which targets the Rohingya as a racial group and is implemented by the state, amounts to the crime against humanity of apartheid.¹⁵

In addition to the daily persecution the Rohingya endure, there is a long history of violent expulsions by the Myanmar security forces, including in 1978, when around 200,000 Rohingya were forced to flee to Bangladesh; and in the early 1990s, when an estimated 250,000 Rohingya were forced across the border (for more information, see section 2.3). Myanmar's long history of atrocities against the Rohingya reached its apogee in 2016 and 2017, a period in which the military undertook successive so-called clearance operations following attacks on police posts by a Rohingya armed group known as the Arakan Rohingya Salvation Army (ARSA). Those military operations attacked Rohingya women, men, and children, making no effort to distinguish people involved in the ARSA attacks from the wider population;¹⁶ credible estimates of the number of Rohingya killed range from 6,700 to more than 10,000.¹⁷ The military also burned hundreds of villages, forcing more than 850,000 Rohingya—roughly 80 to 85 percent of the Rohingya population in northern Rakhine State—to flee to Bangladesh between October 2016 and March 2018.

In early January 2019, the Arakan Army (AA), an ethnic Rakhine armed group, launched attacks on Myanmar police posts in Rakhine State, following months of sporadic clashes between the military and AA in the northern parts of Rakhine State and in neighbouring Chin State.¹⁸ The AA was founded in the late 2000s, the latest in a line of ethnic Rakhine armed groups; it has trained and headquartered in the KIO-controlled areas of Kachin State and, since 2016, fought against the military alongside an alliance of ethnic armed groups in northern Myanmar. Its stated aims include greater autonomy for the ethnic Rakhine people.¹⁹

¹¹ See International Crisis Group, *Myanmar: A New Peace Initiative*, p. 2. For a full list of ethnic armed organizations and when various ceasefires have been signed or broken, see Myanmar Peace Monitor, "Armed Ethnic Groups," <http://www.mmpeacemonitor.org/1426>

¹² See Commander in Chief of the Defense Services (CINCDS), <http://cincds.gov.mm/node/2619>. See also Ye Mon, "Military extends unilateral ceasefire to June 30 after Muse peace talks," *Frontier Myanmar*, 1 May 2019, <https://frontiermyanmar.net/en/military-extends-unilateral-ceasefire-to-june-30-after-muse-peace-talks>

¹³ OCHA, Myanmar: New Displacement in Shan State (1 Jan to 9 Apr 2019), 22 April 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/20190321_Shan_Displacement_22Apr2019.pdf. For more on recent fighting in northern Shan State, see, for example, Chit Min Tun, "Myanmar Army Overruns KIA Outposts in N. Shan State," *The Irrawaddy*, 25 April 2019, <https://www.irrawaddy.com/news/burma/myanmar-army-overruns-kia-outposts-n-shan-state.html>; Lawi Weng, "N. Shan Residents Live in Fear as Rights, Security Situation Deteriorates," *The Irrawaddy*, 12 March 2019, <https://www.irrawaddy.com/opinion/analysis/n-shan-residents-live-fear-rights-security-situation-deteriorates.html>

¹⁴ Photographs of land and identity documents on file with Amnesty International.

¹⁵ See Amnesty International, "Caged without a Roof".

¹⁶ See Amnesty International, "We Will Destroy Everything"; Amnesty International, "We Are at Breaking Point": *Persecuted in Myanmar, Neglected in Bangladesh* (Index: ASA 16/5362/2016), 19 December 2016.

¹⁷ See Médecins Sans Frontières (MSF), *Myanmar/Bangladesh: Rohingya crisis - a summary of findings from six pooled surveys*, 9 December 2017, www.msf.org/en/article/myanmarbangladesh-rohingya-crisis-summary-findings-six-pooled-surveys (estimating that between 9,425 and 13,759 Rohingya died in Myanmar in the first month of the military's operations, including between 6,759 and 9,867 people who died from violence); Independent International Fact-Finding Mission on Myanmar (UN FFM), *Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar*, 17 September 2018, pp. 241-242 (citing other statistical examinations of the death toll in 2017 and stating "the estimate of up to 10,000 deaths is conservative").

¹⁸ See International Crisis Group, *A New Dimension of Violence in Myanmar's Rakhine State*, Asia Briefing No. 154, 24 January 2019.

¹⁹ For more on the history of the Arakan Army, see International Crisis Group, *A New Dimension of Violence in Myanmar's Rakhine State*.

Rakhine State is not covered by the military's unilateral ceasefire declarations in December 2018 or April 2019. In response to the AA's January 2019 attacks, the Myanmar military sent significant troop reinforcements. Fighting has escalated steadily, with near-daily clashes in March and April 2019, and been marked by military violations that at times amount to war crimes.²⁰ Older ethnic Rakhine women and men, in contrast to the other ethnic minorities on which this report focuses, are often being displaced for the first time in their life, though share a history of abuse and neglect by the Myanmar authorities.

After a historic general election in November 2015, the National League for Democracy (NLD), headed by long-time democracy activist Aung San Suu Kyi, took office in March 2016 and cited the peace process and reconciliation as among its top priorities. The military, however, maintains firm control of all defence- and security-related matters, with no oversight, including in its justice processes. The quasi-civilian government has organized several rounds of peace negotiations, referred to as the 21st Century Panglong Peace Conferences, but no real progress has been made toward peace for northern Myanmar or for Rakhine State.

At time of publication, informal talks remained ongoing between the military and the alliance of ethnic armed groups in northern Myanmar²¹—part of the military's claimed rationale for extending the unilateral ceasefire, even as it is repeatedly broken. However, the ethnic armed groups and the Myanmar authorities remain far apart on issues central to peace process. The prospects for an imminent end to fighting appear dim.

1.2 OLDER PEOPLE IN SITUATIONS OF CRISIS

The rights of older people have long received insufficient response from international humanitarian and human rights organizations, including Amnesty International. Compared to other groups with specific risks in situations of armed conflict and humanitarian crisis, the reporting on older people has been limited, as have been the resources dedicated to their needs.²² Human rights law is also less well-defined, or at least less specialized, for older people as compared to other groups—such as children, women, racial and ethnic minorities, and people with disabilities—for which there are human rights treaties that focus on the specific rights of individuals in those groups and on state parties' specific responsibilities.²³

There is no global definition in international law of what constitutes an “older person”. In the African and Inter-American systems, it is defined as age 60 or older, although the Inter-American definition includes some flexibility.²⁴ National law varies significantly around the world, often linked to an age at which pension plans or certain government assistance begins.²⁵ At headquarters, the UN Refugee Agency (UNHCR) defines an “older person” as age 60 or older, but in country operations has at times taken a context-specific approach.²⁶ The Office of the High Commissioner for Human Rights (OHCHR) promotes a context-specific approach, recognizing that “age is a social construct based on custom, practice, and the social role a person plays in his or her community.”²⁷ From a rights perspective, an arbitrary minimum age cut-off is misguided, as it risks failing to respond based on individual rights and needs. “Older age” should be considered, as OHCHR does, according to each context, and, in addition, take into account individuals' self-identification.

The body of work that does exist on older people in situations of crisis comes largely from HelpAge International and from the World Health Organization (WHO). HelpAge International has published research and guidelines on older people's rights in humanitarian emergencies, including related to nutrition interventions;²⁸ health interventions;²⁹ mental health;³⁰ exclusion in humanitarian data;³¹ and best practices

²⁰ For more on the ongoing fighting and abuses, see Amnesty International, “No One Can Protect Us”: War Crimes and Abuses in Myanmar's Rakhine State (Index: ASA 16/0417/2019), 29 May 2019.

²¹ See, for example, Ye Mon, “Military extends unilateral ceasefire to June 30 after Muse peace talks”.

²² For more on under-resourcing, see HelpAge International, *End the neglect: a study of humanitarian financing for older people*, 2016.

²³ For more on efforts to secure a Convention on the Rights of Older Persons, see HelpAge International, Towards a UN convention on the rights of older people, <https://www.helpage.org/what-we-do/rights/towards-a-convention-on-the-rights-of-older-people/>

²⁴ See Protocol to the African Charter on Human and Peoples' Rights on the rights of older persons in Africa, 31 January 2016, Article 1; and Inter-American Convention on Protecting the Human Rights of Older Persons, Article 2 (defining an “older person” as a “person aged 60 or older, except where legislation has determined a minimum age that is lesser or greater, provided that it is not over 65 years”).

²⁵ See, for example, Council of Europe, Recommendation CM/Rec(2014)2: Promotion of Human Rights of Older Persons, adopted by the Committee of Ministers on 19 February 2014, Appendix, para. 2 (“Council of Europe member States have identified chronological ages at national level whereby persons enjoy specific rights and advantages by reason of their older age”).

²⁶ Amnesty International email correspondence with representative of UNHCR, May 2019.

²⁷ OHCHR, Report of the United Nations High Commissioner for Human Rights (2012 ECOSOC Report), UN Doc. E/2012/51, 20 April 2012, para. 8, <https://undocs.org/E/2012/51>

²⁸ HelpAge International, *Nutrition interventions for older people in emergencies*, 2013.

²⁹ HelpAge International, *Health interventions for older people in emergencies*, 2012.

³⁰ HelpAge International, *Older voices in humanitarian crises: Calling for change*, 2016.

³¹ HelpAge International, *More at risk: How older people are excluded in humanitarian data*, 2019.

for responding to specific risks.³² The WHO, for its part, has examined particular risks that older people face in situations of crisis, including related to health, economic well-being, and isolation, and outlined a set of policy recommendations for preparing for and responding to their specific needs.³³

The WHO has also shown the extent of the link between aging and disability. In 2011, the WHO estimated that, worldwide, 46.1 percent of people age 60 and older live with one or more disability; in low- and middle-income countries of Southeast Asia, the estimate was even higher: 58.8 percent.³⁴ Among ethnic minorities who have lived through decades of persecution by the Myanmar military, even the WHO estimate for Southeast Asia is likely to understate the percentage of older women and men with one or more disability. HelpAge International has examined the specific experiences of older people with disabilities in several crises, finding that a variety of physical, attitudinal, and institutional barriers “made it harder for them to escape from danger and exercise their right to humanitarian assistance and participation.”³⁵

In recent years, there have been growing efforts to ensure that humanitarian response, including in situations of conflict and forced displacement, does not exclude or underserve certain segments of the population. In advance of the World Humanitarian Summit (WHS) in May 2016, the Charter on the Inclusion of Persons with Disabilities in Humanitarian Action was developed, which many UN agencies, humanitarian organizations, and states, including key donors, have endorsed.³⁶ During and after the WHS, UN agencies, humanitarian organizations, and states also established a series of commitments under what was termed “Core Responsibility 3: Leave No One Behind”. The commitments focused on the inclusion of underserved and underrepresented groups, ensuring they “actively participate in the planning, design and delivery of programs and have their specific needs and rights systematically met in crises.”³⁷ “Older people” were included in that passage, though their relative invisibility remained apparent in that it was the only time the term appeared in the 36-page document on WHS commitments; other groups—including women and girls; young people; and people with disabilities—are referred to regularly under Core Responsibility 3.³⁸

In 2018, a consortium of humanitarian organizations published the *Humanitarian inclusion standards for older people and people with disabilities*, which include over-arching standards on involving older people in the design and implementation of humanitarian response, as well as specific standards for different thematic aspects of humanitarian assistance, including protection, WASH, food security, shelter, and health.³⁹

The development of detailed humanitarian standards to respond to older people’s rights and needs has been significant, and reflects that many governments, donors, and humanitarian actors understand that efforts have historically been lacking. Progress in implementing those standards, however, remains too slow and too often treated as of secondary importance or as part of a later stage of humanitarian response, rather than an integral consideration from the first moments a humanitarian crisis unfolds.⁴⁰

This report examines how governments, donors, and the humanitarian community are not respecting the rights of older people living in and displaced from crisis-affected areas of Myanmar. It builds on research by HelpAge International and Human Rights Watch that has examined the rights of older people living in other conflict-affected countries, including South Sudan and Ukraine.⁴¹

³² HelpAge International, *Older people in emergencies identifying and reducing risks*, 2012.

³³ WHO, *Older people in emergencies: Considerations for action and policy development*, 2008. See also WHO, *Older persons in emergencies: An active ageing perspective*, 2008.

³⁴ WHO and World Bank, *World Report on Disability*, 2011, https://www.who.int/disabilities/world_report/2011/report.pdf, p. 30 (Table 2.2).

³⁵ HelpAge International and the London School of Hygiene & Tropical Medicine (LSHTM), *Missing millions: How older people with disabilities are excluded from humanitarian response*, April 2018.

³⁶ For more on the charter and the list of endorsing stakeholders, see Charter on Inclusion of Persons with Disabilities in Humanitarian Action, <http://humanitariandisabilitycharter.org/>

³⁷ World Humanitarian Summit (WHS), *Commitments to Action*, 2016,

https://www.un.org/disabilities/documents/desa/whs_commitment_to_action.pdf, p. 32.

³⁸ WHS, *Commitments to Action*, 2016, p. 32. For references to other groups under Core Responsibility 3, see pp. 5-6, 15-20.

³⁹ Age and Disability Capacity Programme (ADCAP), *Humanitarian inclusion standards for older people and people with disabilities*, 2018, https://reliefweb.int/sites/reliefweb.int/files/resources/Humanitarian_inclusion_standards_for_older_people_and_people_with_disabi....pdf

The Age and Disability Consortium that oversees ADCAP includes the following members: CBM, DisasterReady.org, Handicap International, HelpAge International, International Federation of Red Cross and Red Crescent Societies (IFRC), Oxford Brookes University, and RedR UK.

⁴⁰ Amnesty International interviews with senior humanitarian workers and experts on older people’s rights, Dhaka, Bangladesh; Yangon and Myitkyina, Myanmar; and New York, United States, December 2018 to May 2019; and telephone interviews, November 2018 to April 2019.

⁴¹ See, for example, HelpAge International, *Baseline Report: Emergency protection-based support to conflict affected older women and men in the GCAs locations of Donetsk and Luhansk oblasts*, July 2018; HelpAge International and LSHTM, *Missing millions* (examining Tanzania and Ukraine); Humanitarian Policy Group (HPG) and HelpAge International, *Older people in displacement: Falling through the cracks of emergency responses*, July 2018 (examining South Sudan); Human Rights Watch, “Ukraine: Barriers to Free Movement for Older People,” November 2018; and Human Rights Watch, “South Sudan: People with Disabilities, Older People Face Danger,” May 2017.

SOKHINA KHATUN, ETHNIC ROHINGYA, AROUND 90 YEARS OLD

FROM NGA YANT CHAUNG (A) TAUNG BAZAR VILLAGE TRACT, BUTHIDAUNG TOWNSHIP, RAKHINE STATE
DISPLACED SINCE AUGUST 2017, CURRENTLY LIVING IN CAMP #1 EAST (KUTUPALONG), BANGLADESH⁴²



Sokhina Khatun, around 90 years old, stands in her shelter in Camp #1 East, Bangladesh, 19 February 2019. © Reza Rahman / Amnesty International

“My name is Sokhina Khatun. I was around 8 to 10 years old [during the Second World War].

I fled to [Bangladesh] in 2017. I went out after the morning prayer, and I saw killing. Then I fled, I didn't take anything... When we were fleeing, the husband of one of my granddaughters was shot and killed. Three people died together... Two of my grandchildren also got shot—one in the hand, one in the leg...

I came here with only my walking stick [and] this *thami* (longyi). [The Myanmar soldiers] were shooting, homes were burning. I was hiding. My grandson took me to the mountain. [He] left me there. I walked for a while with my stick... then I fell. Anyway, I crossed the valley [to Maungdaw Township].

I was all alone. There was nobody [from my family with me]... I found a boy—I think that boy was sent to me as an angel. There was a stream. I told the boy to help me cross it [because] I didn't have anyone to help me. He held my hand and with one jump, I crossed the stream. I walked for a while, and the boy told me to get on his back. He carried me for a while and then put me on the ground. I lay on the soil. I was very hungry... Someone gave me rice and a banana. I survived like that... When I remember it, I weep.

I've fled [from Myanmar] four times in my life... One time it was to Rangpur, [in what is now north-western Bangladesh]. It was a long time ago, just before the British left... When the [Second World] War started, the massacres began. I was living near [Sittwe] at the time, I was a girl... [When the violence started], we came here. I stayed [in Rangpur] for around seven years. From there, we were brought by boat [back to Myanmar]; 1,300 of us were together, we were brought to Teknaf, and then we took smaller boats back to Myanmar. After coming back, I lived in Taung Bazar. We lived [there] for the last 60 to 80 years.

After that time, we fled another time in 1978. We fled because we had to go for forced labour [with the Myanmar military], pay extortion frequently, and give them chickens. We had to plough for the military... They had been persecuting us for so long and so some of us fled. We stayed for one year in Bangladesh, then [Bangladesh's then-President] Ziaur Rahman sent us back to Myanmar.

⁴² Amnesty International interview, Camp #1 East (Kutupalong Camp), 14 February 2019; and re-interview, 19 February 2019.

We stayed for 10 to 15 years [in Myanmar], then we fled again. We came to Kutupalong... After four years, we went back. It was [Bangladesh Prime Minister] Khaleda [Zia] during that time.

The fourth time was 2017. There has never been peace for us. We've had to flee here frequently.

We were under persecution [in Myanmar] for so long... If we go to the mountains, we're considered rebels... If we're in the village, we're called 'Kalar'.⁴³ We can't keep [sharp farming tools] at home. The military would come and take it from us. We don't have machetes, axes, or anything [for farming work]...

Once I had a [Myanmar nationality card]... a red card... but [in 1979, when] we were going back [to Myanmar from Bangladesh], the card was taken... There were some Myanmar officials. They checked all our belongings and took them... I can't speak for everyone, but mine was taken. Those who hid it, maybe they could save it... After they took the [nationality] card, whenever they came [to do the household registration], they wrote we were 'Bengali'.

After we were sent back in 1979, our movement was restricted. We couldn't go from one village to another... [Before 1978], the [ethnic Rakhine] women came to our house, and we went to theirs. After, that stopped... It happened gradually...

How can we win against them? If the Myanmar authorities didn't start the hostility, we could have lived there. But since the authorities and [ethnic Rakhine] hate us, how will we win them over? ... We want peace. If the country is peaceful, we will be happy... we will go back. Otherwise, we won't go...

We are used to living in our home. Now here [in the refugee camps], we have to stay under tarpaulin... The coming days will be hot. How will we tolerate it? There is no fan.

Here, they give us only rice, lentils, and oil. They're not providing anything else... To cook, we need salt, chili—where are these items? Anyway, we are surviving here with rice.

My number one problem is the latrine. The latrine is down at the bottom [of the hill], it's very difficult for me to go down there. Sometimes I just go inside [my shelter in a pan]... [My daughter] with a physical disability, she throws it away. I've been surviving like that.

I have a problem with my vision, and I don't have any spectacles.

I take many medicines. No one has ever come here [to my shelter to check on my health]. I take Vitalin, [a vitamin supplement]. I take this [for rheumatoid arthritis]. It was given to me by the camp clinic the day before yesterday... Every four to five days, I need to go there. There's another clinic that's closer, but they only give three tablets—they say they're out of medicines... [The closer clinic], it takes maybe 10 minutes, walking. It's just there, but it's no good. To the [better] clinic, I have to go by local transport. Sometimes I pay 5 taka, sometimes the driver doesn't take money. There's no system of assistance [for older people]...

[In addition to medication from the clinic], I buy them [in the market]. There is a box there... I even bought this one. This one cost about 20 taka. I need about 100 to 300 [taka] per month [to pay for medicines].

Here, I live alone [in my shelter].⁴⁴ I told Allah that I will live alone in the graveyard. I don't have anyone.

⁴³ "Kalar" is a derogatory term, derived from the Sanskrit for "black". It is used in Myanmar to describe Muslims, Indians, and others of South Asian descent.

⁴⁴ Sokhina Khatun said that her daughter with a physical disability lived in the same camp block, not far from her shelter. She said her other children, and their families, lived elsewhere in the camp, not close by. Amnesty International interview, Camp #1 East (Kutupalong Camp), 14 February 2019; and re-interview, 19 February 2019.

2. LIVING THROUGH CONFLICT, ATROCITIES

“Those who were able to flee, fled. But those who were older, [those who were] weak, they could not escape.”

Mohamed Zubair, 26, whose 90-year-old Rohingya grandmother was burned to death inside her home by Myanmar soldiers in August 2017 in Chein Kar Li village, Rathedaung Township, Rakhine State.⁴⁵

“I’ve fled so many times since I was 9 years old... I’ve had to be alert all the time. It doesn’t matter what I do—on the farm, in the orchard—I’ve never had peace of mind.”

Nding Htu Bu, 65, an ethnic Kachin woman from Awng Lawt village, Tanai Township, who has lived since June 2018 in Jaw Masat IDP Camp in Myitkyina Township, Kachin State.⁴⁶

Older women and men in Myanmar have experienced a variety of human rights violations in areas where the Myanmar military has undertaken operations against armed groups. Amnesty International has documented incidents across Myanmar in which older people from ethnic minorities were injured or killed by gunshot, by mortar or artillery shells, and by landmines or improvised explosive devices (IEDs).⁴⁷ Amnesty International has also documented incidents in which older people were among a larger group of civilians detained and, at times, subjected to torture or other cruel and inhuman treatment.⁴⁸ The Myanmar military has been overwhelmingly responsible for these crimes, with the exception of maiming and death by IEDs, which are often laid by ethnic armed groups, particularly in northern Myanmar.⁴⁹ Statistics are limited, but one rigorous quantitative survey found that, during the military’s attack on the Rohingya population in the month after 25 August 2017, the highest rates of mortality—by far—were among women and men age 50 and older.⁵⁰

⁴⁵ Amnesty International interview, Kutupalong Camp Extension, Bangladesh, 27 September 2017.

⁴⁶ Amnesty International interview, Jaw Masat IDP Camp, Kachin State, Myanmar, 10 December 2018.

⁴⁷ Amnesty International, “*We Will Destroy Everything*”, pp. 59-111; Amnesty International, “*All the Civilians Suffer*”, pp. 16-19, 22-31, 43-46; Amnesty International interviews with victims and witnesses in Myanmar and Bangladesh, March 2017-April 2019.

⁴⁸ Amnesty International, “*We Will Destroy Everything*”, pp. 25-37; Amnesty International, “*All the Civilians Suffer*”, pp. 14-16, 32-33; Amnesty International, “*No One Can Protect Us*”, pp. 24-25; Amnesty International interviews with victims and witnesses in Myanmar and Bangladesh, March 2017-April 2019.

⁴⁹ For more on ethnic armed groups’ use of IEDs, see Amnesty International, “*All the Civilians Suffer*”, pp. 43-46.

⁵⁰ MSF, *Myanmar/Bangladesh: Rohingya crisis - a summary of findings from six pooled surveys*, 9 December 2017. Epidemiologists experienced in quantitative health surveys oversaw the work, which involved a simple random sample in which households were selected based on randomly-generated GPS coordinates. For more on the methodology, see MSF, *Survey Report: Health Survey in Kutupalong and Balukhali Refugee Settlements, Cox’s Bazar, Bangladesh*, December 2017, pp. 12-16; and MSF and Epicentre, *Retrospective mortality, nutrition and measles vaccination coverage survey in Balukhali 2 & Tasnimarkhola camps*, December 2017, pp. 10-13.

This section focuses on the unique, or at least disproportionately-felt, experiences of older women and men in Myanmar. Older people often remain behind when villagers flee a military advance; when discovered, soldiers at times murder them or subject them to cruel and inhuman treatment. Many older people also face particular—at times deadly—challenges in fleeing Myanmar’s mountainous borderlands, worsened by the military closing off or putting checkpoints on main routes. Finally, many older people in Myanmar have experienced multiple traumatic incidents linked to repeated displacement or to having witnessed the murder or rape of their children and grandchildren. Yet there is almost no psychosocial support aimed at older women and men, including among the refugee and internally displaced populations.

CRIMES UNDER INTERNATIONAL LAW, STEPS TOWARD INTERNATIONAL JUSTICE

The crimes committed by the Myanmar military against older women and men from ethnic minorities are part of a much broader pattern of crimes under international law.

In its attack on the Rohingya population, Amnesty International has documented the military’s responsibility for the crimes against humanity of murder; deportation and forcible transfer; imprisonment or other severe deprivation of physical liberty; torture; rape and other sexual violence; persecution on ethnic and religious grounds; enforced disappearance of persons; apartheid; and other inhumane acts.⁵¹ In addition to crimes against humanity, the UN Fact-Finding Mission (FFM) has said that senior Myanmar officials should be investigated and prosecuted for the crime of genocide.⁵²

In the context of the internal armed conflicts between the Myanmar military and ethnic armed groups in Kachin and northern Shan States, as well as between the Myanmar military and the Arakan Army in Rakhine State, Amnesty International has reported in detail on the military’s responsibility for war crimes and other human rights violations.⁵³ The pattern of abuse against older women and men discussed below, including torture, arbitrary detention, forced labour, and indiscriminate shelling, includes war crimes and other human rights violations. In addition to war crimes, the FFM has said that the military’s crimes in Kachin and northern Shan States since 2011 amount to crimes against humanity.⁵⁴

The Myanmar military has a long history of impunity, as Amnesty International and others have reported in relation to the contexts described in this report.⁵⁵ This impunity is reflected in the experience of older women and men from ethnic minorities, many of who have lived through systemic abuse throughout their lives as well as repeated waves of atrocities without justice or effective remedy (see section 2.3, below).

The prospects for meaningful accountability in Myanmar are non-existent, as the authorities have repeatedly failed to investigate and prosecute perpetrators. International avenues offer the best hope of bringing to justice those most responsible, including senior military officials.

To that end, in September 2018, the UN Human Rights Council established an Independent Investigative Mechanism for Myanmar (IIMM) to “*collect, consolidate, preserve and analyse evidence of the most serious international crimes and violations of international law committed in Myanmar since 2011, and to prepare files in order to facilitate and expedite fair and independent criminal proceedings, in accordance with international law standards, in national, regional or international courts or tribunals...*”⁵⁶ The IIMM is set to begin its work in the coming months, as the FFM completes its mandate in September 2019.

The Office of the Prosecutor of the International Criminal Court (ICC) has also begun a preliminary examination into “*coercive acts having resulted in the forced displacement of the Rohingya people*” from Myanmar to Bangladesh,⁵⁷ after Pre-Trial Chamber I issued a decision that the court may exercise jurisdiction over the alleged deportation of Rohingya people from Myanmar to Bangladesh and potentially other crimes where at least one element of the crime has been committed on the territory of Bangladesh or another state party to the Rome Statute.⁵⁸

⁵¹ For a legal analysis of Amnesty International’s documentation, see Amnesty International, “*We Will Destroy Everything*”, pp. 135-168. For the relevant crimes, see Rome Statute of the International Criminal Court, 2187 U.N.T.S. 90, entered into force 1 July 2002, Article 7(1).

⁵² UN FFM, *Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar*, pp. 351-364.

⁵³ For a detailed analysis, see Amnesty International, “*All the Civilians Suffer*”; and Amnesty International, “*No One Can Protect Us*”.

⁵⁴ UN FFM, *Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar*, pp. 364-374.

⁵⁵ See Amnesty International, “*We Will Destroy Everything*”, pp. 135-168; Amnesty International, “*All the Civilians Suffer*”; UN FFM, *Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar*, pp. 393-418.

⁵⁶ UN Human Rights Council, Resolution 39/2: Situation of human rights of Rohingya Muslims and other minorities in Myanmar, 27 September 2018, para. 22. In December 2018, the UN General Assembly welcomed the creation of the IIMM. UN General Assembly, Resolution 73/264: Situation of human rights in Myanmar, 22 December 2018.

⁵⁷ See Statement of ICC Prosecutor, Fatou Bensouda, on opening a Preliminary Examination concerning the alleged deportation of the Rohingya people from Myanmar to Bangladesh, 18 September 2018.

⁵⁸ ICC Pre-Trial Chamber I, Decision on the “Prosecution’s Request for a Ruling on Jurisdiction under Article 19(3) of the Statute” (ICC-RoC46(3)-01/186), 6 September 2018.

2.1 ABUSED, KILLED IF THEY STAY BEHIND IN VILLAGES

Across Myanmar, the sound of fighting nearby, or a rumour that the Myanmar military will soon enter a village, leads many people to flee to the surrounding forest or mountains. Older women and men often remain behind, however, either because they are physically unable to flee or because they believe themselves to be at less risk and want to remain in their home. In many instances, Myanmar soldiers make no distinction, detaining, torturing, and even killing older women and men who remain in a village.

A 67-year-old ethnic Rakhine farmer from a village in Ponnagyun Township, Rakhine State, told Amnesty International he lived at the back edge of his village and had not noticed it was emptying over several days in March 2019, as a result of fighting between the Myanmar military and the Arakan Army. His hearing is severely impaired, which he said meant he had not heard the fighting or the sounds of other villagers leaving for a makeshift displacement site. One morning in mid-March, the man went to the forest to use the toilet. *“While I went there, the fighting started again,”* he recalled, several weeks later. *“I walk very slowly. By the time I got back, everyone [from the village] was gone.”*⁵⁹

Not long after he returned from the forest, four Myanmar soldiers came to his house, part of a contingent of what the farmer estimated were around 100 to 200 soldiers in the village. He said he saw soldiers kicking down fences around other houses, so he announced his presence to them, hoping they would spare his fence. The soldiers summoned him to his courtyard and then brought him to a centrally-located house in the village; they said their captain wanted to speak with him. He recalled:

“When I got to where the captain was, the soldiers tied my hands... behind my back, with the rope that’s used for cattle. I was tied to a wooden pole at the base of a house. They asked me, ‘Did the AA come to the village?’ I said no, I’d never seen [the AA], just heard of them, and then the soldiers beat me. [The officer] smacked me in the back of my head...”

Another man [from the village] was already there. His hands were tied behind his back, he was lying down. He couldn’t speak because he had been tortured.

*They didn’t give us any food all day. I asked for water from one of the soldiers, and he shared [his water bottle] secretly; he asked me not to let the captain know... I was tied there from 1 p.m. to 9 p.m.—that’s when the soldiers left. They didn’t untie me. Luckily the guy who had been tortured, his tie was loose. He was able to get free and untied me.”*⁶⁰

Amnesty International separately interviewed the other ethnic Rakhine man, in his late 50s, who had come back to the village that morning from where he had been displaced in order to check on his cattle. When soldiers saw him, they tied his hands, forced him to lie on the ground, and kicked him twice in the back of the head; he raised his head reflexively, and a soldier kicked him in the side of the face. The man’s cheek remained swollen and sensitive to touch several weeks later, when interviewed. He said a soldier put a sword to his back and asked him if he knew where the AA was.⁶¹

An 80-year-old retired Rohingya teacher from Kyar Gaung Taung village in Maungdaw Township, Rakhine State, similarly described being detained and beaten by Myanmar soldiers, during an incident in 2017 that preceded the military burning the village and forcing everyone, including the teacher, to flee to Bangladesh. *“Seven or eight days before they set fire to the village... soldiers came to my home, they didn’t even ask me any questions, they just started beating me—with a stick,”* he recalled. *“When the soldiers came, I was the*



A 67-year-old ethnic Rakhine man shows a scar from when Myanmar soldiers bound his wrists with rope and tied him to a wooden pole for hours, 30 March 2019. © Amnesty International

⁵⁹ Amnesty International interview, Sittwe, Rakhine State, Myanmar, 30 March 2019.

⁶⁰ Amnesty International interview, Sittwe, Rakhine State, Myanmar, 30 March 2019.

⁶¹ Amnesty International interview, Sittwe, Rakhine State, Myanmar, 30 March 2019.

only man who was there, the rest were women. [The soldiers] gathered us together. The rest of the men had run away, but I couldn't, because I couldn't run.⁶²

In addition to staying behind when other people in a village flee, older people, and in particular older men who are engaged in farming and raising livestock, are sometimes among the first to check on their village during a break in fighting, due to their deep ties to the land (see text box on page 28). This, like staying behind, puts older people at particular risk of military abuse.

Hpauwung Naw Grawng, an ethnic Kachin man around 60 years old, fled his village in Momauk Township, Kachin State, in November 2011, after months of fighting nearby between the Myanmar military and the KIA. After staying for several years in Je Yang IDP Camp in KIO-controlled territory, “I missed my house,” he recalled. “I went to check on it on 30 July 2014. That’s when I encountered the Myanmar Army.”⁶³

As he was walking, Hpauwung Naw Grawng came across a military checkpoint near Zin War Ka Htaung village. He said the soldiers tied his hands behind his back with rope and accused him of being a KIA spy:

“I was kicked in the side, and I was hit with a rifle butt in my chest. They also hit me on the head with a pistol... I was questioned many times, but I can’t speak the Burmese language. When I couldn’t answer their questions, I was hit again and again.

They brought tools—a shovel. They [showed me] a hole and said they would kill me and bury me in it... Then the [battalion] commander came and said his wife was Kachin, and he let me go... I had 40,000 kyats (US\$41) and 100 yuan (US\$16) in my bag. When the Burmese [soldiers] gave the bag back, [the money was gone]. They took my ID card, they took my sword.

I was released around 8:30 p.m. I was treated in [my village] for about a month. Then I came back here [to Je Yang IDP Camp] at night. ... I walked [off the main roads], joining cattle traders, to avoid any soldiers. It’s been years that I’ve not gone back to the village. I pray any time 30 July comes... When the weather gets cold, I hurt a bit sometimes. The injury is still there.”⁶⁴

Older people from ethnic minorities across Myanmar have, as a result of not fleeing or returning first to a village, faced similar patterns of arbitrary detention, inhuman treatment, and torture at the hands of the Myanmar military. But the scale and nature of the military’s crimes has been particularly vicious against older Rohingya women and men, especially during the atrocity-marred operations in northern Rakhine State in October 2016 and again in August and September 2017.

In late 2017, Médecins Sans Frontières (MSF) undertook methodologically rigorous health surveys in the Bangladesh refugee camps, estimating that at least 6,700 Rohingya women, men, and children were killed in the first month after 25 August 2017. MSF reported the highest mortality rates—by a significant margin—among Rohingya age 50 and older, with men dying at higher rates than women. MSF estimated the reported death of 5.47 percent of Rohingya women and men age 50 and older during the first month of the military’s operation, compared to 1.70 percent of children between 0 and 5 years old and 1.95 percent of people between 5 and 49 years old.⁶⁵ As Amnesty International and others have reported, Myanmar soldiers burned hundreds of Rohingya villages during that period, often with people—disproportionately older people—still inside their homes.⁶⁶ They committed similar crimes, on a smaller scale, in October and November 2016.⁶⁷

Shamsul Islam, 37, said Myanmar soldiers entered his village of Pwint Hpyu Chaung, in Maungdaw Township, in November 2016. His father, Foyaz Ahmed, 60, had a physical disability that left him unable to walk; and his grandfather, Abdul Jabbar, was around 90 years old and could walk only slowly and for short distances. Shamsul Islam told Amnesty International that he and another family member made a makeshift chair and carried the two older men to the roadside. “We thought that since they were just two older people, nothing would happen to them,” Shamsul Islam recalled.⁶⁸ As the shooting got closer, the rest of the family fled to the mountainous area nearby; from there, they could see houses burning in the village.⁶⁹

⁶² Amnesty International interview, Camp #14 (Hakimpara Camp), Bangladesh, 16 February 2019.

⁶³ Amnesty International interview, Je Yang IDP Camp, Kachin State, Myanmar, 7 March 2017.

⁶⁴ Amnesty International interview, Je Yang IDP Camp, Kachin State, Myanmar, 7 March 2017. The conversion from Myanmar kyat and Chinese yuan to US dollars is based on the prevailing rate in July 2014, when the incident occurred.

⁶⁵ MSF, *Myanmar/Bangladesh: Rohingya crisis - a summary of findings from six pooled surveys*, 9 December 2017.

⁶⁶ See Amnesty International, “We Will Destroy Everything”; Amnesty International, “My World Is Finished”, p. 20; UN FFM, *Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar*, pp. 148, 197, 199, 209, 210, and 219 (including, on page 210, the conclusion that “[d]eath by burning in this manner disproportionately affected vulnerable persons less able to run and escape from the ‘clearance operations’, including the elderly, disabled, young children and pregnant women”).

⁶⁷ See Amnesty International, “We Are at Breaking Point”.

⁶⁸ Amnesty International interview, Camp #17, Bangladesh, 24 February 2019.

⁶⁹ Amnesty International interview, Camp #17, Bangladesh, 24 February 2019.

That night, Shamsul Islam heard from an aunt that, as her family had fled, soldiers detained his 65-year-old uncle, Zurul Hoque, and another man, letting women and children go. They would never again see the four men. On the third day after fleeing, Shamsul Islam and another uncle went back to the village to look for their relatives. They found charred remains inside the grandfather's house; Shamsul Islam said he identified his father and grandfather based on their body types. He dug a hole nearby and interred the remains.⁷⁰

A Rohingya farmer in his 60s from Kha Maung Seik village tract, Maungdaw Township, similarly said Myanmar soldiers entered the Rohingya area early on or around 27 August 2017. The man, his wife, and his adult children fled and hid in the nearby forest, but his father, who he said was around 100 years old, stayed behind. *"My father didn't want to leave his village,"* the farmer said. *"He had a lot of land there... My father received the land from his grandfather. We've nursed that land... from my grandfather's father."*⁷¹

As the farmer heard gunfire, he sent two of his adult sons back to bring his father out of the house. When the sons returned, they said they had seen their grandfather tied, put inside his house, and then the soldiers set the house on fire. *"When they told me these things, I became almost senseless,"* he recalled. *"I'm getting older. When I recall what happened to my father, I get even more discombobulated."*⁷²

As with Shamsul Islam's father, many older people with disabilities stay behind because they are physically unable to flee. Mariam Khatun, around 50 years old, from a village in Thit Tone Nar Gwa Son village tract in Maungdaw Township, Rakhine State, recalled fleeing to the nearby forest with her three children when Myanmar soldiers entered their village several days after 25 August 2017. *"My parents were left behind in the home,"* she said. *"I had two young children, how could I take them as well? ... My parents were physically unable to move. We had to carry them [everywhere]. We even had to feed them."*⁷³

Mariam Khatun said that as she and her children reached the river next to the village, she looked back and saw the village burning. After fleeing to Bangladesh, she sent a son-in-law back to look for her parents, Iman Sherif and Sura Khatu, both of who were around 80 to 90 years old. Only ashes remained where their home stood. She believes they must have been burned to death inside the home.⁷⁴

In October 2017 and June 2018 reports on the military's atrocities against the Rohingya, Amnesty International described several other incidents in which soldiers burned older Rohingya women and men to death inside their homes, after they were either unable to flee or had chosen to remain behind, believing they would be safe.⁷⁵ In Rohingya villages where the largest massacres occurred, older people were killed in great number. For example, a list put together by Rohingya activists and community leaders of 352 Rohingya women, men, and children killed in Chut Pyin village, Rathedaung Township, on 27 August 2017, indicates that 43 victims, or more than 12 percent, were age 55 or older, including 10 women and men in their 80s or 90s.⁷⁶ A list put together by Rohingya activists and community leaders of 82 Rohingya men and boys killed in Maung Nu village, Buthidaung Township, also on 27 August 2017, similarly indicates that 10 victims, or more than 12 percent, were age 60 or older, including six men in their 80s or 90s.⁷⁷

UNHCR has reported that 3.6 percent of the Rohingya in the Bangladesh refugee camps are 60 years or older.⁷⁸ The MSF mortality survey, age breakdowns of specific massacres, and qualitative findings all suggest that the number should be much higher, but that a disproportionately large part of the older Rohingya population was killed during the military's campaign.

⁷⁰ Amnesty International interview, Camp #17, Bangladesh, 24 February 2019. Shamsul Islam said his father and grandfather would have been unable to return to the grandfather's house on their own, so believed that soldiers must have taken them there before setting the house on fire. There were no direct witnesses available to confirm precisely what happened before the men died.

⁷¹ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 21 February 2019.

⁷² Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 21 February 2019.

⁷³ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 21 February 2019.

⁷⁴ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 21 February 2019.

⁷⁵ Amnesty International, *"My World Is Finished"*, pp. 11, 20; Amnesty International, *"We Will Destroy Everything"*, pp. 78, 80, 82.

⁷⁶ List of people killed in Chut Pyin, on file with Amnesty International. For more on the Chut Pyin massacre, see Amnesty International, *"We Will Destroy Everything"*, pp. 32-34, 36, 62-68, 90-91.

⁷⁷ List of people killed in Maung Nu, on file with Amnesty International. For more on the Maung Nu massacre, see Amnesty International, *"We Will Destroy Everything"*, pp. 69-72, 92-93.

⁷⁸ UNHCR, *Refugee Response in Bangladesh*, 15 May 2019, https://data2.unhcr.org/en/situations/myanmar_refugees. Precise estimates and age breakdowns of the Rohingya population are limited, as the Myanmar authorities refused to allow them to identify as Rohingya in the 2014 census, the country's first in 30 years, thereby excluding them. For more on the problematic 2014 census, see International Crisis Group, *Counting the Costs: Myanmar's Problematic Census*, Briefing No. 144 / Asia, 15 May 2014.

2.2 CHALLENGES OF FLEEING FIGHTING, ABUSES

When fleeing military abuses, and fighting more generally, many older women and men across Myanmar described particular difficulties, often linked to having limited mobility. The military frequently compounds the difficulty of escaping by blocking main roads and by erecting checkpoints that cause people, out of fear, to take more treacherous forest or mountain paths to avoid encounters with soldiers. The result, at times, is serious illness, injury, or even death for older women and men trying to get to safety.

Nding Htu Bu, 65, was working on her farm in Awng Lawt village,⁷⁹ Tanai Township, Kachin State, when she heard artillery shells exploding nearby in the afternoon of 11 April 2018. She sheltered against a riverbank for the rest of the day, then, when there was a break in the explosions after nightfall, decided to flee, along with others from the village. It would take her more than a month to reach Jaw Masat IDP Camp in Myitkyina Township. She described the journey to Amnesty International:

“It was very difficult. I got separated from [most of] my family... I’m very old, and one of my daughter’s legs wasn’t working well, so it took us a long time [to flee], compared to other people.

We walked day and night... My feet were full of bruises, I couldn’t even walk sometimes... We heard gunshots behind us and in front of us. It was terrifying... My ankle twisted [when walking through a stream]. Sometimes it still gets swollen...

We brought some rice... We’d get some cassava in the forest and some vegetables, and that’s pretty much how we survived... It was difficult because we only had one pair of clothes. We were never dry, because it was raining. We had to climb up many steep slopes, up mountains... We cut some branches and put them on the floor [of the jungle], and that’s where we slept.”⁸⁰

Nding Htu Bu said that, in addition to her and her daughter having to walk slowly, the journey took longer because the Myanmar military blocked the main road, forcing people to navigate a forest path. She said everyone in her family survived, though her injuries continued to bother her eight months later, but that a religious leader in her group of displaced people passed away from illness along the way.⁸¹

Older ethnic Kachin, Shan, and Ta’ang women and men typically described walking for hours through the forests or mountains, before being able to take transport—whether motorbike, shared van, or cargo truck—to the closest town’s monastery or church. Older Rohingya women and men overwhelmingly undertook the entire journey out of Rakhine State on foot, or at least to boat points on the Naf River or Bay of Bengal, where they paid Bangladeshi fishermen to take them across to Bangladesh. For older Rohingya in Maungdaw Township, the journey usually took a day or two. For those in Buthidaung and Rathedaung Townships, it often took more than a week, during which they crossed rivers, creeks, and mountains, and snuck through forests to avoid soldiers. Making matters worse, most Rohingya fled in haste, unable to carry any food; on the way to Bangladesh, they found only empty villages the military had burned.

“When I was fleeing, I fell. My arm broke, and the joint here [in my hand] was also broken,” recalled Hala Banu, a Rohingya woman around 70 years old who said it took weeks to get to Bangladesh from her village in Nga Yant Chaung (a) Taung Bazar village tract, Buthidaung Township. *“Sometimes I walked, sometimes my children carried me... The climbing was so difficult. We crossed five or six hills... Sometimes we were starving, we were eating only the soil. After coming [to Bangladesh], we were given rice and so relieved.”⁸²*

As with Hala Banu, many older Rohingya women and men made much of the journey on their own, using walking sticks fashioned from bamboo; they described needing the most help when ascending the mountains or getting stuck in knee- or waist-deep mud, due to the heavy rains that time of year. The rains created additional risks, as described by Shair Banu, a Rohingya woman around 90 years old from Kyauk Phyu Taung village, Buthidaung Township: *“The suffering was unbearable. It was raining heavily. The small canal we had to pass through was full of water. I thought it was shallow and got down [in it]. The current was so strong, I thought it would take me away... Some people saw and rescued me.”⁸³*

Several dozen older Rohingya women and men, including Sokhina Khatun (see profile on page 16), described family members, neighbours, and even strangers carrying them for a significant part, and at times all, of the journey—on their backs, in blankets hung on bamboo poles, and on makeshift stretchers. Such efforts, despite the threat that people would be killed if found by soldiers, saved many older people’s lives.

⁷⁹ Awng Lat, or Aung Lat, is the Kachin name, and the name widely used in local and international media reports. Amnesty International was told the village’s official name, as reflected in the MIMU database, is Sa Rar Ka Htaung, but was not able to definitively confirm that.

⁸⁰ Amnesty International interview, Jaw Masat IDP Camp, Myitkyina Township, Kachin State, Myanmar, 10 December 2018.

⁸¹ Amnesty International interview, Jaw Masat IDP Camp, Myitkyina Township, Kachin State, Myanmar, 10 December 2018.

⁸² Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 19 February 2019.

⁸³ Amnesty International interview, Camp #17, Bangladesh, 24 February 2019.

Many other older people died on the way; the challenge of the journey for those with limited mobility is likely one reason for the disproportionately high mortality rate of Rohingya over 50 years old. A 61-year-old Rohingya farmer from Mee Chaung Zay village tract in Buthidaung Township described fleeing for two weeks before reaching Bangladesh; during the journey, he said he watched as another older man, being carried by his children, was set down on the path, as the children and the rest of the group continued forward. *“I don’t know if he was alive or dead at the time—maybe the children weren’t able to keep carrying him,”* he said.⁸⁴

A 20-year-old Rohingya man from Maung Nu village in Buthidaung Township told Amnesty International that, after fleeing his village, where several relatives were killed in one of the larger massacres of the military’s post-25 August 2017 operations,⁸⁵ he hired two people to carry his grandfather to Bangladesh. They hung a blanket from a bamboo pole and put his grandfather inside, each porter carrying an end of the pole. The grandfather had been a farmer for most of his life but had become sick in recent years, eventually living with a physical disability that left him unable to walk and in need of help to eat.⁸⁶

After a week, the group reached Fatiah Dala—a pass that cuts between the mountains that divide Buthidaung and Maungdaw Townships. The grandson said the mountain pass becomes so narrow in some places that people have to cross makeshift bridges one or two at a time. In an area only slightly wider, with slippery stones lining the path, a rumour came through the group of people fleeing that the military was shooting people as they exited the mountain pass. Panic ensued, the grandson recalled:

*“I couldn’t hear any bullets, but there was so much noise from other people and the heavy rain... [The two porters] just dropped my grandfather and ran away. They were in front of us... It was so crowded, there was no way even to bend down. If you did, there would have been a stampede—you’d be finished... I saw [my grandfather] as we went by, but I couldn’t stop, I had to go with the crowd... I was carrying my younger sister. It was raining, and there was no way to go back.”*⁸⁷

He had not heard news of his grandfather in the 18 months since, but assumed he died there on the path. *“Sometimes my relatives here, they ask me, ‘How could you leave behind your grandfather?’”* the grandson recalled, tearfully. He said he had seen around ten other older people who were left behind along the path, huddled in blankets similar to what was used to transport his grandfather.⁸⁸



A boy carries an older Rohingya woman in the refugee camps in Bangladesh, 28 September 2017. © Andrew Stanbridge / Amnesty International

⁸⁴ Amnesty International interview, Camp #8 East (Balukhali Camp), Bangladesh, 22 February 2019.

⁸⁵ For more detail on what happened in Maung Nu, see Amnesty International, *“We Will Destroy Everything”*, pp. 69-72, 92-93.

⁸⁶ Amnesty International interview, Camp #8 (Balukhali Camp), Bangladesh, 22 February 2019.

⁸⁷ Amnesty International interview, Camp #8 (Balukhali Camp), Bangladesh, 22 February 2019.

⁸⁸ Amnesty International interview, Camp #8 (Balukhali Camp), Bangladesh, 22 February 2019.

2.3 REPEATED DISPLACEMENT, A LIFETIME OF ABUSE

Across Myanmar, many older women and men have faced fighting and oppression throughout their life. They have often been displaced from their home and village as children, as young adults, and again in older age.⁸⁹ For many, the recurrent distress and disruption has had a profound psychosocial and economic toll.

Among 53 older Rohingya women and men interviewed by Amnesty International in Cox's Bazar in February 2019, two had been forced to flee to Bangladesh four times in their life,⁹⁰ 11 three times, 24 twice, and 16 once, including two men who had been in Bangladesh as registered refugees since the 1990s. In addition to the expulsions to Bangladesh, dozens of older Rohingya women and men described having fled frequently to the mountains or jungles near their villages for days or, less frequently, weeks at a time.

Amnesty International interviewed 26 older women and men who were among the approximately 200,000 Rohingya who fled to Bangladesh in 1978, as a result of what the Myanmar military government referred to as Operation *Nagamin* (Dragon King)—a purported effort, prior to a national census, to remove “foreigners” who were in the country “illegally”.⁹¹ Many older Rohingya said that, at the time, they knew, or had heard stories from neighbouring villages, of people being arrested and subjected to torture. “*They were looking to arrest us,*” recalled Hala Banu, around 70 years old. “*They’d give a different excuse: ‘Why is your house in this way? Why is this name different?’ They were asking different questions and arresting people.*”⁹²

Shiraz Uddin, 62, remembered the military checking people’s arms to see where they had received vaccines. “*They used to say that those who have vaccinations on the right arm are from Bangladesh,*” he said.⁹³ Shiraz Uddin, like many others, said he fled in advance of the military coming to his village, fearing they would find some pretext to arrest and mistreat him, irrespective of the documents showing his family had always lived in the same village.⁹⁴ Each older person interviewed by Amnesty International who fled to Bangladesh in 1978 described pressure to return around a year later, including through the curtailment of food assistance, after the governments of Bangladesh and Myanmar reached a repatriation agreement.⁹⁵

Amnesty International interviewed 20 older Rohingya women and men who fled to Bangladesh in 1991 or 1992. Mia Hossain, a 72-year-old Rohingya farmer from Pa Da Kar Ywar Thit village, Maungdaw Township, said he fled to Bangladesh first in 1978 and again in 1992, the second time because of the Myanmar military’s practice of forced labour. Once when forced to porter and work in a military camp, Mia Hossain watched as another Rohingya forced labourer died when soldiers refused medical treatment when he fell sick. After being released from that round of forced labour, Mia Hossain fled to Bangladesh—one of around 250,000 Rohingya who left in 1991 and 1992. He was one of around 30,000 Rohingya granted refugee status in Bangladesh in the 1990s, and has remained in the camps since.⁹⁶

Sara Khatun, in her early 70s, fled to Bangladesh from Zay Di Taung village, Buthidaung Township, in 1978 and 1991, similarly linking the 1991 exodus to “*excessive forced labour*”; she said the military forced her husband to porter for weeks at a time, which left him unable to work on the family’s farm and pushed them toward starvation.⁹⁷ Unlike Mia Hossain, Sara Khatun was sent back to Myanmar after a year in Bangladesh. “*They told us the [Myanmar] authorities would treat us nicely, that’s why we went back,*” she recalled.⁹⁸

Instead, each time they returned to Myanmar, voluntarily or involuntarily, older Rohingya women and men describe finding themselves ever more persecuted. While the full history of Myanmar’s persecution of the Rohingya is beyond this report’s scope, it is essential to understand the specific psychosocial harm that older Rohingya have experienced; they, uniquely, have lived through each iteration of Myanmar’s oppression.

Many older Rohingya in the Bangladesh camps showed Amnesty International identity documents that recognized them as nationals of Myanmar, including the Union Certificate of Citizenship (UCC), issued on a small scale in the first decade after independence; and the National Registration Card (NRC), a three-panel

⁸⁹ Section 4.1 of this report examines the separate issue of the impact on older people of recurrent, short-term displacement during relatively limited periods of time, including some of the specific humanitarian needs and risks associated with such displacement.

⁹⁰ In both instances, the first displacement was during the Second World War, before the independence or creation of Myanmar or Bangladesh. People were technically fleeing from one area of the British Empire to another. What is meant here is that those people were fleeing from their villages in what is now the country of Myanmar to an area in what is now the country of Bangladesh.

⁹¹ Amnesty International interviews with older Rohingya women and men, Bangladesh, February 2019. See also C.R. Abrar, “Repatriation of Rohingya Refugees,” 1995, <http://www.burmalibrary.org/docs/Abrar-repatriation.htm>; and K. Maudood Elahi, “The Rohingya Refugees in Bangladesh: Historical Perspectives and Consequences,” in *Refugees: A Third World Dilemma* (New Jersey: Rowman & Littlefield, 1987).

⁹² Amnesty International interview, Camp #1 East (Kutupalong Camp), 19 February 2019.

⁹³ Amnesty International interview, Age Friendly Space in Camp #18, 23 February 2019.

⁹⁴ Amnesty International interview, Age Friendly Space in Camp #18, 23 February 2019.

⁹⁵ Amnesty International interviews, Bangladesh, February 2019.

⁹⁶ Amnesty International interview, Kutupalong RC, Bangladesh, 15 February 2019.

⁹⁷ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 19 February 2019.

⁹⁸ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 19 February 2019.

identity document, green for men and pink for women, issued under the 1948 Citizenship Law.⁹⁹ Other older Rohingya women and men described having one or more of these cards, but said they were lost when the military burned their village in 2016 or 2017 or had previously been stolen or confiscated by members of the Myanmar security forces.¹⁰⁰ Several older Rohingya men interviewed by Amnesty International had, through prior recognition of their nationality, been employed as government clerks or teachers or, in one case, been a soldier in the Myanmar military for 14 years. Such positions would be impossible today, unless a Rohingya was able to secure papers that identified him or her as from another, “recognized” ethnic group.

In addition to having their citizenship, identity, and access to state jobs stripped, most older Rohingya women and men described having their land confiscated little by little, year after year, by the Myanmar authorities—often to build new military or police bases, as northern Rakhine State became more militarized; or to build or expand villages for predominantly Buddhist ethnic groups.¹⁰¹ Older Rohingya also lived through ever-worsening movement restrictions. Most said that, as children and early in adulthood, they moved freely from village to village in Rakhine State; several older men described travelling freely to other parts of Myanmar, including Yangon (then known as Rangoon)—one recalling that a plane flight from Sittwe to Yangon cost 180 kyats at the time—and even to other countries, including Saudi Arabia for the hajj and to Singapore and Malaysia for business. Older Rohingya recalled how, over the course of their life, the authorities restricted their movements more and more until, by 2012, they could not walk to a neighbouring village without permission and, often, having paid a bribe. To travel outside northern Rakhine State became virtually impossible.¹⁰² Amnesty International has concluded that, at least since 2012, the system of discrimination and persecution against the Rohingya amounts to the crime against humanity of apartheid.¹⁰³



Mohammed Ayub, 61, who survived the 27 August 2017 massacre in his village of Maung Nu, Buthidaung Township, Rakhine State, shows his National Registration Card (NRC), in Balukhali Camp, Bangladesh, 22 February 2019. © Reza Rahman / Amnesty International

⁹⁹ For more information on the issue of citizenship and identity, and the different documents that Myanmar has used over the years, see Amnesty International, *“Caged without a Roof”*; and Jose Maria Arraiza & Oliver Vonk, *Report on Citizenship Law: Myanmar* (Global Citizenship Observatory, October 2017), http://cadmus.eui.eu/bitstream/handle/1814/48284/RSCAS_GLOBALCIT_CR_2017_14.pdf

¹⁰⁰ Amnesty International interviews with dozens of older Rohingya women and men, Bangladesh, February 2019. For more on the 1982 Citizenship Law, see Amnesty International, *“Caged without a Roof”*, pp. 28-30.

¹⁰¹ Since the early 1990s, the Myanmar government has implemented a policy of establishing “model villages” in northern Rakhine State. The policy involves relocating ethnic Rakhine and other non-Rohingya people to newly built villages, where, in addition to a new home, they are given livestock and income generating items such as tractors. The project was run by the Ministry for Development of Border Areas and National Races, better known by its Myanmar acronym “NaTaLa”. NaTaLa villages were often built on land confiscated from Rohingya using Rohingya villagers for forced labour. Many Rohingya see the villages as an attempt to deprive them of land and dilute the ethnic makeup of northern Rakhine State. For more information, see Amnesty International, *“Caged without a Roof”*.

¹⁰² Amnesty International interviews, Bangladesh, February 2019. See also Amnesty International, *“Caged without a Roof”*.

¹⁰³ For more information on movement restrictions and their impact on other rights, see Amnesty International, *“Caged without a Roof”*.

The persecution culminated in the military operations in 2016 and 2017, during which the military's crimes under international law forced more than 850,000 Rohingya women, men, and children into Bangladesh.¹⁰⁴ While the apartheid state and recent atrocities have affected the entire Rohingya population, older Rohingya women and men described a specific anguish of remembering what things were like before—before Myanmar stripped them of their most basic rights, before being treated, in the words of many older Rohingya interviewed by Amnesty International, as “animals” or “not as humans.”¹⁰⁵ A Rohingya man in his early 90s from Maung Gyi Taung village, Buthidaung Township, recalled, in words echoed by many others:

“What was it like before and what is it like now? Where was I before and where I am now? ... I try not to remember all of these things. If I think of them, it's intolerable... I try to spend the whole day now playing with children. When I remember these very old stories, my heart is on fire.”¹⁰⁶

Among 21 older ethnic Kachin women and men interviewed in December 2018 and March 2019, eight had been displaced internally four or more times in their life, dating back to the 1960s; six had been displaced three times; six people twice; and one person once.¹⁰⁷ For example, a 71-year-old Kachin woman said she had to flee her childhood home in Shan State in the early 1960s; fled repeatedly, for weeks at a time, in the 1970s and 1980s, from the village in Kachin State to which she had moved after the first displacement; and fled again in June 2011, when artillery shells exploded near her home.¹⁰⁸ She said that both as a child and again in the 1980s, her family fled repeatedly to avoid the military's practice of forced labour, describing:

“I've been fleeing my whole life: as a child; as a mom, carrying my child on my back. There was one time [in 1971] when one of my children was only four days old, and I had to flee.

In my village, there's a [Myanmar] military base, so whenever they've started an operation, they started in our village. It also meant the KIA attacked [the military base] several times. Whenever they did, we suffered. It's been a difficult life... Our lives improved a little during the ceasefire agreement period, and then the conflict started again and we had to run away.”¹⁰⁹

Older Kachin women and men described a psychological toll of being unable to ensure their children completed schooling, as a result of the frequent displacement. They also described a devastating economic impact of having to leave their farmland, often for years at a time; of having to start anew in a different village, or to return to an old village to rebuild burnt homes; and of having to replace, again and again, most of their accumulated possessions, which they had to abandon when fleeing.

Htu Bu, 58, said she had fled three times in her life from her village in Sumprabum Township, Kachin State. Once, in 1983, she and her family fled to the jungle during harvest time, because they saw Myanmar soldiers entering the village. She said they stayed in the jungle for several months, surviving on vegetables they picked. Her daughter, who was around 2 years old, fell sick with diarrhoea. “We didn't have any medicines, so we pounded some traditional herbs. But she died,” Htu Bu recalled.¹¹⁰

When they were finally able to return to the village, everything was gone. “When we fled, we had to leave all the belongings—the chickens, the pigs, the cows,” Htu Bu said. “We left all the paddy. When we returned, all the pigs and cows were slaughtered. The house was ransacked... Nothing was left.”¹¹¹ It would be the first of several times her family would have to restart from nothing.

In addition to the cumulative effect of repeated displacement over a lifetime, many older Kachin women and men displaced at the time of this research expressed concern about whether and how they would be able to start over this time. Nding Htu Bu, 65, was forced to flee her village of Awng Lawt, in Tanai Township, in April 2018, when the Myanmar military fired artillery rounds that exploded in and around the village, near where the KIA had a post. She said her husband died of natural causes nine years earlier and that, when she had to flee in April 2018, “I left the house, the furniture, the dowry that I got—everything.”¹¹² She heard from other people who returned to check on the village that her house had been damaged and ransacked,

¹⁰⁴ See Amnesty International, “We Will Destroy Everything”, pp. 135-169; UN FFM, *Report of the detailed findings of the Independent International Fact-Finding Mission on Myanmar*, pp. 351-364, 382-420.

¹⁰⁵ Amnesty International interviews with older Rohingya women and men, Bangladesh, January 2018 and February 2019.

¹⁰⁶ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

¹⁰⁷ During previous research trips to northern Myanmar, Amnesty International interviewed other older Kachin women and men displaced by fighting since 2011. That research did not focus on the specific experience of older people, so delegates did not systematically ask questions about how many times each person had fled during his or her life. As a result, those interviews are not included in the statistics.

¹⁰⁸ Amnesty International interview, name of IDP camp withheld to protect her anonymity, Kachin State, Myanmar, 11 December 2018.

¹⁰⁹ Amnesty International interview, name of IDP camp withheld to protect her anonymity, Kachin State, Myanmar, 11 December 2018.

¹¹⁰ Amnesty International interview, Jan Mai Kawng IDP Camp, Myitkyina, Kachin State, Myanmar, 10 December 2018.

¹¹¹ Amnesty International interview, Jan Mai Kawng IDP Camp, Myitkyina, Kachin State, Myanmar, 10 December 2018.

¹¹² Amnesty International interview, Jaw Masat IDP Camp, Myitkyina, Kachin State, Myanmar, 10 December 2018.

leaving her with nothing. She hoped the fighting would end, and yearned to return to her village, but said she was in such a difficult financial situation that she could not afford to purchase needed medicines.¹¹³

Similarly, a 62-year-old Kachin woman from Myitkyina Township, Kachin State, told Amnesty International that she had fled her village because of fighting and military abuses in the 1970s, in 1987, and in 2011; she remained in an IDP camp in Myitkyina town in December 2018. *“It’s been really difficult, we had to start all over again and again,”* she recalled. *“We had to borrow some money from the locals everywhere [we fled to]. When we built up [our lives], then we fled again. When I think about it, I want to cry.”*¹¹⁴



Htu Bu, 58, stands by her shelter in Jan Mai Kawng Catholic Church IDP Camp, Kachin State, 10 December 2018. She said she had been forced to flee her village three times during her life, and this time has been displaced for more than seven years, since 2011. © Hkun Lat / Amnesty International

OLDER PEOPLE’S CONNECTION TO THEIR LAND AND HOME

While people of all ages in Myanmar feel close ties to their land and home, older women and men often describe a particularly profound connection. Being displaced from that land can be a specific and unique source of hardship and anguish. At times, that leads older people to refuse to leave or to return to a village where fighting is ongoing, putting them at elevated risk.

In Myanmar, displacement in older age often means leaving a home and village where someone has lived for the past 60 or more years. As they age, older people in rural Myanmar, from where most displacement occurs, regularly continue to farm and engage in other activities that provide for their food and livelihood. Displaced in camps, often far from home, a life of self-sufficiency and resourcefulness is replaced by dependency and invisibility. A 63-year-old ethnic Kachin woman from Khaunglanhpu Township, Kachin State, said her village was so isolated it could only be reached on foot; she had been displaced to an IDP camp near Myitkyina for five years. *“In our village, we didn’t need to buy anything; we didn’t need money, we just [cultivated] what we needed,”* she said. *“I want to return, but... there could be landmines.”*¹¹⁵

Densely-populated camp environments are challenging for people who have always lived in rural villages, surrounded by land. Nur Mohammed, a 70-year-old Rohingya man from a village east of Taungpyoletwea, in Maungdaw Township, told Amnesty International: *“There, we had our land, our forests. Here, we live in such a small space. We only came here... to save our lives.”*¹¹⁶ Kamalun Nisa, a Rohingya woman around 75 years old, expressed similar difficulties in the Bangladesh camps: *“My shelter is next to a busy road...*

¹¹³ Amnesty International interview, Jaw Masat IDP Camp, Myitkyina, Myanmar, 10 December 2018.

¹¹⁴ Amnesty International interview, name of IDP camp withheld to protect her anonymity, Kachin State, Myanmar, 10 December 2018.

¹¹⁵ Amnesty International interview, name of IDP camp withheld to protect her anonymity, Kachin State, Myanmar, 11 December 2018.

¹¹⁶ Amnesty International interview, Camp #8 East (Balukhali Camp), Bangladesh, 16 February 2019.

It's difficult for me because there's always so much movement around my shelter. In that place, I really suffer. There is no space, there are too many people in Kutupalong."¹¹⁷

Several humanitarian workers in northern Myanmar contrasted the feelings of older people in the IDP camps there with the feelings of younger people. *"Older people just want to go back, whereas the younger [generation] is thinking about education and other things in urban areas that aren't [in the village],"* said a program manager from an international humanitarian organization.¹¹⁸ A program coordinator from a local humanitarian organization believed, based on her observations in the IDP camps, that *"some [older people] feel like they are a burden,"* after long providing for themselves in their village.¹¹⁹ *"It's about their psychological well-being,"* she continued. *"Older people, who can't stand being in the camp, they are starting to question whether they will die in the camps. They want to die in their villages."*¹²⁰

As with older Kachin women and men who have lived in IDP camps in northern Myanmar for almost eight years, many older Rohingya who were forced to flee to the refugee camps in Bangladesh connect feelings about land and home with a need to return to the place of their ancestors before dying. *"I want to go back to my home,"* said a 90-year-old Rohingya man from Sin Thay Pyin village, Maungdaw Township. *"My relatives, they are buried there—I always pray to Allah... let me also die and be buried in my country."*¹²¹ Abul Hossain, a Rohingya man around 85 years old, from Myo Mi Chaung village in Maungdaw Township, said similarly: *"When I remember my ancestors, I miss them. I can't go see [their graves]... I've had to come here [to Bangladesh]. I miss my country very much."*¹²²

Among both displaced Kachin and displaced Rohingya, older people's desire to return to their village is compounded by concerns that their land will be confiscated in their absence. For decades, the authorities have taken, without compensation, Rohingya land in Rakhine State to build military and police bases and to build or expand villages for predominantly Buddhist ethnic minorities. Since August 2017, when military operations drove more than 740,000 Rohingya into Bangladesh, that dynamic has repeated.¹²³

Rohingya refugees in Bangladesh are acutely aware of the bulldozing of burned Rohingya villages and of the new construction the Myanmar authorities are overseeing in northern Rakhine State, including on former Rohingya villages and farmland.¹²⁴ A 70-year-old Rohingya man from Thit Tone Nar Gwa Son village tract told Amnesty International he had heard that, in his village, which the military burned in August 2017, the authorities had *"made it flat"* with bulldozers and constructed *"long houses. Then they brought the [ethnic] Mro from the hills"* to live there.¹²⁵ This is precisely what has happened, as Amnesty reported in June 2018.¹²⁶ *"On the radio, we listen to [the Myanmar authorities] say they are ready for us to return,"* the man said. *"But they have done nothing. Our houses, our lands are gone."*¹²⁷

In Kachin State, banana plantation owners, some with ties to Chinese businesspeople, are taking over land of Kachin families displaced by the conflict.¹²⁸ A 62-year-old woman from Ta Law Gyi village in Myitkyina Township, Kachin State, was one of several older displaced people who expressed fear her land would be confiscated. *"If there is peace, I'd want to return right away, because I am worried I will lose our land,"* the woman said. *"The banana plantation farm has reached right next to our paddy field... The Chinese, they [expanded] a road in the middle of the paddy field. We've heard they will take over [our land]."*¹²⁹

The longing for their land, and the fear of its confiscation, drives some older women and men to return to their home, whether to stay or to check on it temporarily, even when fighting is ongoing or landmines have been laid in the area, as seen in the case of Hpauwung Naw Grawng, described on page 21. A senior humanitarian worker in northern Myanmar described another incident from late 2018 in which a 75-year-old woman in northern Shan State was displaced by fighting but quickly returned to her farm, because she needed to tend to her crops. Fighting broke out again and she was shot and killed.¹³⁰

¹¹⁷ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

¹¹⁸ Amnesty International interview, location withheld to protect anonymity, December 2018.

¹¹⁹ Amnesty International interview, location withheld to protect anonymity, December 2018.

¹²⁰ Amnesty International interview, location withheld to protect anonymity, December 2018.

¹²¹ Amnesty International interview, Camp #11 (Balukhali 2 Camp), Bangladesh, 16 February 2019.

¹²² Amnesty International re-interview, Camp #1 West (Kutupalong Camp), Bangladesh, 19 February 2019.

¹²³ See Amnesty International, *"We Will Destroy Everything,"* pp. 123-149; Reuters, "Erasing the Rohingya: Point of No Return," 18 December 2018, <https://www.reuters.com/investigates/special-report/myanmar-rohingya-return/>

¹²⁴ Amnesty International interviews, Bangladesh refugee camps, February 2019.

¹²⁵ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 14 February 2019.

¹²⁶ See Amnesty International, *"We Will Destroy Everything,"* pp. 131-132.

¹²⁷ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 14 February 2019.

¹²⁸ For background on the issue of banana plantations in Kachin State, see Hein Ko Soe and Ben Dunant, "Kachin's plantation curse," *Frontier Myanmar*, 17 January 2019, <https://frontiermyanmar.net/en/kachins-plantation-curse>; and Chan Thar, "Chinese banana plantations flourish as villagers lose their land in Kachin," *Myanmar Times*, 22 June 2018, <https://www.mmtimes.com/news/chinese-banana-plantations-flourish-villagers-lose-their-land-kachin.html>

¹²⁹ Amnesty International interview, Jan Mai Kawng IDP Camp, Myitkyina, Kachin State, Myanmar, 10 December 2018.

¹³⁰ Amnesty International interview, location withheld to protect anonymity, December 2018.

2.4 IMPACT OF ATROCITIES AGAINST THEIR CHILDREN

Many older people described the murder or rape of one or more children by Myanmar soldiers, and in some cases witnessed what happened. The emotional and psychosocial impact is overwhelming (see text box, below). In the context of rural Myanmar, where older people often continue to live with or close to adult children, the loss of an adult child also has a devastating economic impact on older people, especially when the adult child had become the primary breadwinner, for example in leading the farming of family land.

Given the scale of the military's atrocities against the Rohingya, Amnesty International most often heard of the death of children or grandchildren from older women and men in Bangladesh. At least 18 older Rohingya interviewed by Amnesty International said they had children or grandchildren who were killed by the military in 2016 or 2017; one older woman had lost six of her children. For example, Rahmat Ullah, a Rohingya man in his early 60s, broke down crying as he recounted seeing two of his sons—Abdu Rahman, 18; and Hefzur Rahman, 15—shot and killed when Myanmar soldiers entered his village of Myin Hlut, in Maungdaw Township, and opened fire on people fleeing in late August 2017.¹³¹ Similarly, a 75-year-old Rohingya man from Maung Nu village, Buthidaung Township, said his 40-year-old son was killed during the massacre of men and boys there on 27 August 2017, recalling, *“He was a government teacher. He was very talented, always top of his class... At night, it's difficult for me to sleep because I miss him.”*¹³²

Several older people blamed themselves for what happened to their children, adding to the anguish. A man in his late 50s from Kyun Pauk village, Buthidaung Township, recounted how when soldiers and Border Guard Police came to his village in September 2017, he hid in nearby vegetation; his wife, daughters, and grandchildren remained home.¹³³ The security forces entered the house and raped the man's daughter and two daughters-in-law.¹³⁴ After the security forces left that night, he returned home. *“They told me they were violated,”* he recalled, having to stop several times as he cried; he said he wished he had not fled, even though he believed that if he had been at home, soldiers would have killed him or taken him away.¹³⁵

While the death or rape of a child was most widespread among older Rohingya, Amnesty International heard similar experiences from older ethnic Kachin, Rakhine, Shan, and Ta'ang civilians. For example, a 68-year-old ethnic Rakhine woman from a village in Mrauk-U Township, Rakhine State, said that, on the morning of 19 February 2019, her son went to a mountainous area near their village to check on their chili pepper farm. *“I said, ‘Come back, okay?’ and he said he'd come back the same day,”* she recalled.¹³⁶ Fighting between the Myanmar military and the AA happened nearby several hours later, according to the woman, and she never saw her son again. He is one of six ethnic Rakhine and Mro men who remain missing from that day, as described in Amnesty International's May 2019 briefing; all are presumed to have been killed by the military.¹³⁷ *“I'm just overwhelmed by this loss,”* the woman said. *“I think I will die from this grief.”*¹³⁸

In addition to the psychosocial harm, the death of adult children often has major economic consequences for older people, particularly those still living in their village or who are displaced to somewhere other than a formal IDP or refugee camp. For example, Yar Maela Aung, a Ta'ang woman in her mid-60s from Loi Pyet village, Namhsan Township, northern Shan State, said her son, Aung Than, 24, was killed when Myanmar soldiers forced him to porter for them on 24 June 2017. Fighting occurred between the military and TNLA; other porters escaped, but soldiers detained Aung Than. Several days later, Yar Maela Aung saw his body with a bullet wound in the head and bruises up and down his legs.¹³⁹ She described the impact on her:

*“Aung Than worked at the tea farm. He picked tea, cleaned the farm. He wasn't married... He's the only one who supported me. I have other sons, but they have families—they have to look after their children. My son who supported me is dead. No one will look after me now.”*¹⁴⁰

Similarly, a 63-year-old ethnic Shan woman from a village in Namtu Township, northern Shan State, told Amnesty International that Myanmar soldiers killed her 22-year-old son and his brother-in-law in May 2014. She said the soldiers accused them of being informants for the Shan State Army-North; they beat the son's brother-in-law to death inside the village, then took the son to a military camp, where he was detained. The military released him after around 10 days; the woman said he returned home with scars on his back and

¹³¹ Amnesty International interview, Balukhali Camp, Bangladesh, 21 January 2018. Rahmat Ullat fled to the mountains with others from his village; he returned several days later and found his sons' bodies, each with gunshot wounds to the chest, but was unable to bury them.

¹³² Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 14 February 2019.

¹³³ Amnesty International interview, near Phalungkhali market, Bangladesh, 24 September 2017.

¹³⁴ Amnesty International interviews with father and two of the rape survivors, near Phalungkhali market, Bangladesh, 24 September 2017.

¹³⁵ Amnesty International interview, near Phalungkhali market, Bangladesh, 24 September 2017.

¹³⁶ Amnesty International interview, Sittwe, Rakhine State, Myanmar, 29 March 2019.

¹³⁷ See Amnesty International, *“No One Can Protect Us”*, pp. 25-27.

¹³⁸ Amnesty International interview, Sittwe, Rakhine State, Myanmar, 29 March 2019.

¹³⁹ Amnesty International interview, Lashio, Shan State, Myanmar, 29 July 2017.

¹⁴⁰ Amnesty International interview, Lashio, Shan State, Myanmar, 29 July 2017.

swelling all over his body. “After he got home, he vomited a lot of blood,” she recalled. “Not long after, he died... He’s the son who would have taken care of my husband and me. After he died, it caused us many hardships.”¹⁴¹ She said that if her son were alive, he would have helped her husband and her farm their land, which has become harder for them to work long hours on; instead, she struggles to support her son’s widow and two children, who she said were unable to attend school because of the family’s lack of money.¹⁴²

Older people, and in particular older women, whose adult children are killed often become the primary caregiver of grandchildren, which comes with financial, physical, and emotional responsibilities. Aye Ei, a Ta’ang woman in her early 70s from Pain Hwe village,¹⁴³ Kutkai Township, northern Shan State, lost her 35-year-old daughter, Aye Am, and her 44-year-old son-in-law, Aik Dat, when a mortar shell fired by the Myanmar military landed outside the couple’s house on 26 June 2017. Aye Ei told Amnesty International that she depended on the couple’s farming for food and financial support; when interviewed one month after the shelling, she was caring for the five children her daughter and son-in-law left behind.¹⁴⁴

In the refugee camps in Bangladesh, Amnesty International interviewed at least four older Rohingya women who were the primary caregiver for one or more grandchildren. In its written responses to Amnesty International questions, the UNHCR office in Bangladesh indicated that family counting of the Rohingya refugee population had identified 4,647 families “as older persons at risk with children”.¹⁴⁵



Aye Ei, early 70s, holds a family photograph that includes her daughter and son-in-law who were killed when the Myanmar military fired a mortar shell that landed outside their home, 30 July 2017. © Minzayar Oo – Panos / Amnesty International

¹⁴¹ Amnesty International interview, Lashio, Shan State, Myanmar, 25 March 2019.

¹⁴² Amnesty International interview, Lashio, Shan State, Myanmar, 25 March 2019.

¹⁴³ This is the Ta’ang name of the village. Amnesty International has not been able to determine the Burmese name and spelling.

¹⁴⁴ Amnesty International interview, Kutkai Township, Shan State, Myanmar, 30 July 2017.

¹⁴⁵ UNHCR written response, 31 May 2019, p. 3. UNHCR’s response said further that, of the 290,300 refugees registered as of 31 May 2019, “5,946 persons with vulnerabilities have been identified as primary caregivers (of whom 546 are older persons with vulnerabilities).”

LACK OF PSYCHOSOCIAL SUPPORT FOR OLDER PEOPLE

In Myanmar's conflict-affected borderlands, traumatic experiences are endemic. Millions have been affected by fighting, including by being displaced. Tens of thousands have had family members killed.

Older women and men from ethnic minority areas have often experienced recurrent trauma or distress. Many have been victims of serious violations, including the military's decades-long practice of forced labour.¹⁴⁶ As described above, many have also been displaced repeatedly and had children who were killed. Yet there are few psychosocial programs that reach older people, much less respond to their specific needs, even as part of the humanitarian response in northern Myanmar and in Bangladesh.

The Bangladesh country director of an international humanitarian organization said: *"From an aging lens, older people in the camps are even more vulnerable. They've lost their life savings, their home, their relationships, their skills [relevant to their living situation]. Many of them have lost their adult children. Many of them are adjusting to a new family [and] situation in the camps... Many organizations are working on psychosocial care [in the camps]... but no one thought of psychosocial care for older people. [The humanitarian response is] deprioritizing older people's mental and physical well-being."*¹⁴⁷

During research in Kachin, Rakhine, and Shan States in Myanmar, and in the refugee camps in Bangladesh, the only psychosocial program for older people that Amnesty International encountered was part of the Age Friendly Spaces that HelpAge International and its partners run in six of the 34 Bangladesh camps. The Age Friendly Spaces provide medical care in gender-separated facilities to women and men age 50 and older; non-food items like walking sticks and blankets; protection monitoring; and, critically, psychosocial counselling. Two counsellors—one woman and one man—are in each Age Friendly Space.¹⁴⁸

Mahamuda, 55, said that six of her seven children were killed on 27 August 2017 during the military's massacre of Rohingya women, men, and children in Chut Pyin village, Rathedaung Township; she was herself shot and beaten by soldiers, surviving because neighbours rescued her from a pond. She told Amnesty International that, in the months after arriving to Bangladesh, she was very thin, struggling to process what happened. After the Age Friendly Space was established in late 2017 or early 2018, she spoke with the female counsellor. *"She assisted me,"* Mahamuda said. *"She talked with me."*¹⁴⁹

Over time, Mahamuda was hired as a volunteer for the Age Friendly Space, visiting older people in Camp #13 who had difficulty leaving their shelter. *"When we go house to house, they tell us their problems—that they have leaky tarpaulin sheets or other problems with their shelter. We tell [the camp management], World Vision, and they help [fix it]... There was a very serious problem in the upper part [of the camp] with access to water. When we told them about it, they installed [a water point]."*¹⁵⁰ Mahamuda's work as a volunteer had, along with the counselling, helped her significantly. *"I have lost my children, but Allah has given me others [to care for],"* she said.¹⁵¹

The type of support that Mahamuda has received, including a humanitarian organization actively involving older people in its work, remains extremely limited in Myanmar and in Bangladesh. The humanitarian response in both countries is undeniably overstretched, in part due to the overwhelming number of refugees in Bangladesh and the general donor fatigue with the conflicts in northern Myanmar, where many people have been displaced for eight years and new displacement continues. Psychosocial care, and medical care more generally, remains underfunded and understaffed to meet the needs that exist. Even in the current funding environment, however, donors and humanitarian actors could do more to ensure that their assistance is inclusive—responding to the needs of all segments of the population, without discrimination. Such efforts are, at present, falling short with respect to older people.

¹⁴⁶ See, for example, International Labour Organization (ILO), *Forced labour in Myanmar (Burma): Report of the Commission of Inquiry appointed under article 26 of the Constitution of the International Labour Organization to examine the observance by Myanmar of the Forced Labour Convention, 1930 (No. 29)*, 2 July 1998, <http://www.ilo.org/public/english/standards/relm/gb/docs/gb273/myanmar.htm>; and Richard Horsey, *Ending Forced Labour in Myanmar: Engaging a Pariah Regime* (London: Routledge Contemporary Southeast Asia Series, 2011). In interviews with Amnesty International, older women and men, including ethnic Kachin, Rohingya, and Shan civilians, regularly described having been forced to do labour for the military. Amnesty International interviews, Bangladesh and Myanmar, 2017-2019.

¹⁴⁷ Amnesty International interview, Dhaka, Bangladesh, February 2019.

¹⁴⁸ Amnesty International visits to Age Friendly Spaces and interviews with several people involved in running them, February 2019.

¹⁴⁹ Amnesty International interview, Age Friendly Space in Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

¹⁵⁰ Amnesty International interview, Age Friendly Space in Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

¹⁵¹ Amnesty International interview, Age Friendly Space in Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

AYE HMAN, ETHNIC TA'ANG, AROUND 68 YEARS OLD

FROM MAN LAN VILLAGE, NAMHSAN TOWNSHIP, SHAN STATE

TEMPORARILY DISPLACED TO LASHIO AFTER SOLDIERS KILLED HER SON IN JUNE 2017¹⁵²



Aye Hman holds a photograph of her deceased son, Kyaw Aung, in Lashio, northern Shan State, 27 July 2017. © Minzayar Oo – Panos / Amnesty International

“Fighting was happening around our village [in late June 2017]. The day after, the Tatmadaw came to the village and arrested everyone, sending all of the villagers to the monastery.

They first arrested a small group of people. They accused them of being TNLA soldiers, or supporting the TNLA soldiers, and questioned them. Then they called for everyone [to go to the monastery].

I went [to the monastery] at around 9 a.m. Then we heard a big explosion, so we tried to go back to our houses. We tried to hide, but the Tatmadaw caught us and said we all have to go to the monastery. They came to our house [in the evening] and arrested us.

I can't speak Burmese, but they were pointing their guns at us and shouting at us. We were very afraid. We couldn't even look at their faces. We just hunched over and didn't look at them. If we looked at them, they'd point their guns. They did this to everybody.

We spent three nights and four days at the monastery. My son was killed [there]... His name was Kyaw Aung; most people called him Akyaw. He was 38 years old. He wasn't married, he still lived with my husband and me... We were together [at the monastery] when they said my son had to go downstairs. They said they had to take a photo of him—they took photos of all of the men.

My son has a [developmental] disability. He can't reply well to questions. So they beat him... They were asking if anyone was a [TNLA] soldier, and my son, due to his [disability], he didn't know how to respond. They also saw a scar on his face, from when he had fallen down. [From the scar], they suspected he was a soldier. They arrested him and beat him. My husband was there. He saw all of this. I was upstairs.

They used wood [to] beat him. They struck him over and over, with their fists, their boots, and the wood. He was injured on his head—the injuries were very serious. Then they brought him to another place... First they beat him in the monastery. [Later], I saw a lot of blood [on the floor]...

¹⁵² Amnesty International interview, Lashio, Shan State, Myanmar, 27 July 2017. Aye Hman was 66 years old when interviewed by Amnesty International on 27 July 2017.

The soldiers brought a lot of the villagers to Namhsan [town]. [When the villagers got there], they didn't see my son, so they phoned the monk and said he was missing, they asked him to check around... The soldiers had thrown his body out. It was found between Man Lan and Nam Len villages. He was already dead.

My son looked handsome, but when he walked, his legs were not good. He [shuffled]. Since he was born, he had this... He also had a developmental [disability].

Even though he had a [developmental disability], he worked for our family, for our livelihood. He supported us. We depend on our tea farm. My husband and I, we're getting old, we can't work like before. Akyaw did most of the work there. He didn't get a lot of income, but we depended on him...

No one will help us now, for our survival.

I want people to know what happened... We don't want to go back [home]. My son won't be in the village [anymore]. I don't want to go back.

3. HUMANITARIAN RESPONSE IN BANGLADESH

“We’ve been here for 18 months, but it truly feels like forever, and it feels like it might never end.”

A 65-year-old Rohingya man from a village in Maungdaw Township, living in Balukhali 2 Camp in Bangladesh.¹⁵³

“The distance [to the latrine] isn’t so far, but the problem is that it’s not flat land. I’d have to go up and down the hills.”

Abul Hossain, around 85 years old, from Maungdaw Township, living in Camp #1 West (Kutupalong Camp) in Bangladesh.¹⁵⁴

More than 910,000 Rohingya women, men, and children have been forced into Bangladesh as a result of successive campaigns of violence by the Myanmar security forces. Around 600,000 fled to Bangladesh in the two months after 25 August 2017 alone.¹⁵⁵ The scale of the refugee influx, in such a short period, put enormous demands on the humanitarian community. In many ways, it has responded remarkably.

Older Rohingya women and men remain largely invisible to the humanitarian response, however. Several senior humanitarian workers spoke of older people as “only” a small part of the refugee population, and one that was rarely considered at length in planning.¹⁵⁶ There are debates about how people are being counted and how older age is defined (see text box, on next page), but even the lowest figures indicate that there are more than 30,000 Rohingya women and men age 60 and older among the refugee population.¹⁵⁷ Their specific rights and needs, and the risks that many of them share, are often neglected.

In the most fundamental aspects of humanitarian assistance—shelter, water, sanitation, health, and food—the response in Bangladesh is falling short for many older Rohingya women and men. The situation tends to be worse for older people who are living alone or who are shelter-bound. The Bangladesh government and the humanitarian community must together redouble their efforts to respond to older people’s needs and risks, respecting and fulfilling their rights to physical and mental health; and to an adequate standard of

¹⁵³ Amnesty International interview, Balukhali 2 Camp, Bangladesh, 14 February 2019.

¹⁵⁴ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 17 February 2019.

¹⁵⁵ See Inter Sector Coordination Group (ISCG), Situation Report: Rohingya Refugee Crisis, 29 October 2017, https://reliefweb.int/sites/reliefweb.int/files/resources/171029_weekly_iscg_sitrep.pdf

¹⁵⁶ Amnesty International interviews, Cox’s Bazar, Bangladesh, February 2019.

¹⁵⁷ See UNHCR, Population data and key demographical indicator - 15 May 2019, <https://data2.unhcr.org/en/documents/details/69523>

living, which includes the rights to food, water, and sanitation.¹⁵⁸ As a state party to the Convention on the Rights of Persons with Disabilities (CRPD), Bangladesh, working with the humanitarian community, also has a responsibility to ensure the rights of people with disabilities, including older people with disabilities, to, among other things, non-discrimination; protection and safety; full inclusion and participation; personal mobility; health; and an adequate standard of living.¹⁵⁹ A more inclusive humanitarian response is also essential to meet the Humanitarian Charter's core principles of impartiality, non-discrimination, and of a right to life with dignity;¹⁶⁰ the World Humanitarian Summit commitments to not leave anyone behind;¹⁶¹ and the *Humanitarian inclusion standards for older people and people with disabilities*.¹⁶²

NEED FOR BETTER AGE-, SEX-, AND DISABILITY-DISAGGREGATED DATA

The humanitarian response in Bangladesh has been undermined by a lack of inclusion in data collection and by insufficient disaggregation of data by age, sex, and disability. It has led to the relative invisibility of certain groups, including older people, and meant some programming decisions have been based, and continue to be based, on incomplete or even inaccurate assumptions and analyses.

During the first months of the refugee crisis, UNHCR “*did not initially have permission to conduct individual registration,*” according to its response to Amnesty International questions. Instead, beginning in October 2017, it worked with Bangladesh to undertake a “*Family Counting exercise,*” in which basic information was obtained about a family, including on age, sex, and some vulnerabilities; data about the refugee population was published online and updated twice monthly.¹⁶³ In June 2018, UNHCR and the Bangladesh government jointly launched the individual registration process; by June 2019, more than 21 months into the crisis, only around one-third of the refugee population was registered.¹⁶⁴ UN agencies and humanitarian organizations continue to rely on the family counting data, or on even more limited and non-inclusive means of data collection, which do not adequately capture individual needs and risks.¹⁶⁵

In future humanitarian crises, host governments, with greater pressure from donor governments if necessary, should ensure individual registration begins sooner. When that fails to happen, UN agencies need to prioritize other ways of collecting and disseminating more complete data, with a focus on inclusion. Exercises like family counting inevitably lead to less accurate statistics, including in the assessment of risks and needs, such as those associated with older age and with disability. UNHCR said the ongoing registration exercise “*collects solutions-related individual data and will lead to creation of a consolidated, unified database with comprehensive population data for protection, assistance, and solutions.*”¹⁶⁶ The importance of that individual data speaks to the gap that has existed without it—a gap that has undermined the humanitarian response to older refugees’ rights.

Relying on family counting also means a lack of voice and representation of groups that typically hold less power within a community, including women, older people, and people with disabilities. Older people’s under-participation in data collection is a recurrent problem in humanitarian contexts.¹⁶⁷

As part of the family counting, UNHCR has gathered and published some age- and sex-disaggregated data. As of 15 May 2019, it reported that, of the more than 910,000 Rohingya refugees in Bangladesh, more than 30,000 were age 60 or older, including around 16,000 women and 14,000 men.¹⁶⁸

In its data, UNHCR disaggregates to the following age brackets: 0-4, 5-11, 12-17, 18-59, and 60+ years old.¹⁶⁹ To uphold older people’s rights, better practice would be to disaggregate into smaller brackets (e.g.,

¹⁵⁸ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, Articles 11 and 12.

¹⁵⁹ Convention on the Rights of Persons with Disabilities (CRPD), adopted by the UN General Assembly in resolution 61/106, 13 December 2006, UN Doc. A/RES/61/106, Articles 2, 4, 5, 9, 11, 19, 20, 25, 28, 31.

¹⁶⁰ *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response* (Fourth Edition), 6 November 2018, pp. 28-32, <https://spherestandards.org/handbook/editions/> (in particular the “Common principles, rights, and duties” on pages 29-31).

¹⁶¹ WHS, *Commitments to Action*, pp. 5-6, 15-20.

¹⁶² ADCAP, *Humanitarian inclusion standards for older people and people with disabilities*.

¹⁶³ UNHCR written response, 31 May 2019, p. 1.

¹⁶⁴ UNHCR written response, 31 May 2019, pp. 1-2.

¹⁶⁵ Amnesty International interviews with humanitarian workers, Cox’s Bazar, Bangladesh, February 2019. See also, for example, IOM written response, 30 May 2019, p. 1 (noting that it relies on UNHCR’s family counting data and that its own “*Needs and Population Monitoring Unit collects data primarily through Key Informants Methodology. This involves asking a community leader to describe the needs and perceptions of households that fall within a block or boundary for which he/she is responsible and doesn’t allow age disaggregation*”).

¹⁶⁶ UNHCR written response, 31 May 2019, p. 1.

¹⁶⁷ See HelpAge International, *More at risk: How older people are excluded in humanitarian data*. The report finds that under-inclusion of older people is linked to, among other things, a lack of policies on inclusion among many humanitarian organizations; attitudes among staff that de-prioritize older people’s participation; a misconception that including older people will be expensive; a lack of understanding of the intersection of aging and other identities, including gender and disability; and a lack of analysis even when relevant data is collected.

¹⁶⁸ See UNHCR, Population data and key demographical indicator - 15 May 2019, <https://data2.unhcr.org/en/documents/details/69523>

¹⁶⁹ UNHCR written response, 31 May 2019, p. 1.

60-69, 70-79, 80-89, 90+), allowing for a more nuanced understanding of experiences at different ages.¹⁷⁰ That is true both within what UNHCR defines as “older age”—60 years and older—and in the other bracket for adults: people age 18 to 59. Among the Rohingya population, which has faced decades of persecution, there are very different needs and risks among the lower and upper ends of that age range.

Related, UNHCR should adopt a more context-specific approach to “older age,” rather than using 60 as a minimum cut-off. It has, in some instances—noting that, “*given the average life expectancy of 66 years old*” in Myanmar, UNHCR used an age threshold of 50 and older during a November 2017 assessment to help inform its programming in the Bangladesh refugee camps.¹⁷¹ But in the analysis and dissemination of data, UNHCR still starts at age 60 and includes everyone older than that in one bracket. That is not unique to UNHCR; it is a common decision, and problem, in humanitarian response.¹⁷²

By contrast, for its programming in the Bangladesh refugee camps, HelpAge International has defined “older people” as from age 50, in part because it believes the lived experience of the Rohingya population means issues associated with aging are likely to begin earlier and in part because it felt people 50 and older were falling through the cracks.¹⁷³ In the six camps where it runs programs, HelpAge and its local partners indicated that people age 50 and older comprise around 10 percent of the population.¹⁷⁴

Insufficiently disaggregated data is a problem for other issues as well, including disability. During the family counting exercise, “*disability was recorded at a category level,*” according to UNHCR, without a breakdown of the type or severity of the disability. The ongoing individual registration process, by contrast, includes disaggregation into seven sub-categories, such as visual impairment, physical disability (moderate or severe), and mental disability, which UNHCR says allows for more specific needs to be “*identified, assessed by Protection staff, and referred to specialized interventions when required.*”¹⁷⁵

That is important progress, for the one-third of refugees who have been registered. For the two-thirds who remain unregistered, however, there continues to be insufficient understanding of the range of existing capacities and needs, including among older people with disabilities.¹⁷⁶ It shows the importance of beginning registration earlier, or of ensuring that family counting exercises—or targeted assessments that supplement that exercise—are updated to better allow for proper disaggregation based on disability.

Several humanitarian actors in Bangladesh said the insufficient disaggregation of data has undermined the response to older people and to other groups like people with disabilities, as it has inhibited an understanding of the range of needs that exist linked to different social identities and their intersection.¹⁷⁷ A country director of a humanitarian organization working on these issues told Amnesty International, “*If you don’t know the exact figure, how are you going to plan your response?*”¹⁷⁸

Related, older women and men have often been excluded from questions about sexual and gender-based violence (SGBV), a problem not limited to the humanitarian response in Bangladesh.¹⁷⁹ In standard SGBV assessments, the cut-off age has been 49 years old, based on what is considered “reproductive age”.¹⁸⁰ A senior humanitarian worker who focuses on older people’s rights told Amnesty International, “*It’s assumed that if you’re older than that, it doesn’t happen,*” so the question typically is not asked.¹⁸¹

While the Myanmar military primarily targeted young women and girls for rape and gang rape, soldiers committed SGBV against women age 50 and older as well. Amnesty International documented several incidents of SGBV against older women, including when soldiers searched under women’s clothing to steal money, jewellery, and other valuables.¹⁸² Amnesty International also documented sexualized torture against Rohingya men, including older men, who were detained in Border Guard Police bases.¹⁸³ By not

¹⁷⁰ See HelpAge International, *More at risk: How older people are excluded in humanitarian data*.

¹⁷¹ UNHCR written response, 31 May 2019, pp. 1, 4.

¹⁷² See HelpAge International, *More at risk: How older people are excluded in humanitarian data*.

¹⁷³ Amnesty International interviews, Dhaka and Cox’s Bazar, Bangladesh, February 2019.

¹⁷⁴ Amnesty International interviews, Dhaka and Cox’s Bazar, Bangladesh, February 2019.

¹⁷⁵ UNHCR written response, 31 May 2019, pp. 1-2.

¹⁷⁶ Amnesty International interview, Dhaka, Bangladesh, 13 February 2019; interview, Cox’s Bazar, Bangladesh, 22 February 2019; and telephone interview, 3 March 2019.

¹⁷⁷ Amnesty International interview, Dhaka, Bangladesh, 13 February 2019; interview, Cox’s Bazar, Bangladesh, 22 February 2019; and telephone interview, 3 March 2019.

¹⁷⁸ Amnesty International interview, Dhaka, Bangladesh, 13 February 2019.

¹⁷⁹ Amnesty International telephone interview, 27 November 2018; telephone interview, 17 January 2019; and interview, Dhaka, Bangladesh, 13 February 2019.

¹⁸⁰ For more on this issue, see Violence Against Women and Girls (VAWG), *Brief on Violence Against Older Women*, May 2016.

¹⁸¹ Amnesty International telephone interview, 27 November 2018.

¹⁸² Amnesty International, “*We Will Destroy Everything,*” pp. 96-105. See also MSF, “*No One Was Left: Death and Violence against the Rohingya in Rakhine State, Myanmar,*” 9 March 2018, p. 18 (indicating that MSF clinics treated survivors of SGBV who were 50 years old).

¹⁸³ Amnesty International, “*We Will Destroy Everything,*” pp. 25-37. See also Women’s Refugee Commission, “*It’s Happening to Our Men as Well: Sexual Violence Against Rohingya Men and Boys,*” November 2018.

asking older women and men questions about SGBV, the humanitarian response seems likely to have missed people who may need SGBV-related services, including medical or psychosocial support.

UNHCR has, amid the constraints of the family counting exercise, included vital questions aimed at identifying people, including older people, with particular risks—several of which, such as older people living alone and older people acting as primary caregivers, feature in this chapter’s analysis. UNHCR’s family counting identified 4,647 families of “*older persons at risk with children*”; the current data from the registration process suggests the number might be lower.¹⁸⁴ UNHCR’s family counting also identified “*787 older persons at risk... as living alone*,” a group of individuals that Amnesty International’s interviews show face particularly acute challenges in meeting their basic needs; the current data from the registration process suggests the number of such people might be even higher.¹⁸⁵

In general, responding effectively to individual rights and needs begins with inclusive design in data collection and assessment. In the Bangladesh refugee camp context, some of the problem lies with the initial constraints on and further delays in individual registration. But even with those constraints, more could have been done, and could still be done, to better identify the full range of capacities and needs.

3.1 LATRINES AND BATHING FACILITIES

Among older Rohingya refugees interviewed by Amnesty International, one of the most frequently cited problems in the camps is the lack of access to a latrine or bathing facility. Even older people with moderate mobility, who visit neighbours and pray at a nearby mosque, describe having to use a pan or pot in their shelter—as the closest latrine requires traversing terrain that is too difficult. A lack of lighting in the camps compounds the problems at night. For older people with physical disabilities, the challenges are worse.

Over the last 21 months, the Bangladesh authorities and humanitarian actors have together made considerable improvements to camp infrastructure, including the number of latrines. According to Sphere standards, there should be a communal latrine for every 20 people and such latrines should be no more than 50 metres from an individual’s shelter.¹⁸⁶ During the chaotic first phase of the crisis, the average people per latrine fell well short of the standards; the quality of construction was also uneven, and many latrines were too close to water points.¹⁸⁷ After the construction of more than 55,000 latrines in 2018, the situation improved significantly for most refugees; the lead UN agencies in Bangladesh reported that, by the end of 2018, 71 percent of the targeted population in camp and host community settlements had access to “*functional latrines of agreed standards*,”¹⁸⁸ though the “*unplanned nature of settlements has hampered the siting of latrines and water sources in relation to risks of contamination*.”¹⁸⁹

But for many older people, accessibility appears to depend primarily on luck—luck tied to where someone set up shelter initially and to where humanitarian actors have constructed latrines. From the first days of the refugee response through the period of research for this report, there has been inadequate attention to the rights and needs of older people, for example by ensuring they and those with whom they live are housed in flatter areas that make latrines and other camp services most accessible and by selecting locations for new latrines with a specific mindfulness to people, including older people, with limited mobility.

The current situation does not respect many older people’s rights to sanitation and to dignity, the latter of which is at the core of international human rights law and the principles of humanitarian work.¹⁹⁰

¹⁸⁴ UNHCR written response, 31 May 2019, p. 3. Of the one-third of the refugee population that has been registered, “*546 older persons with vulnerabilities have been identified as primary caregivers*”—which, if the percentage holds even roughly, would result in a figure that, while still considerable, is significantly less than what was identified in the family counting exercise.

¹⁸⁵ UNHCR written response, 31 May 2019, pp. 2-3. Of the one-third of the refugee population that has been registered, “*10,120 have been identified as older persons, of whom 841 are recorded as living alone. 1,771 of those older persons were identified as having a vulnerability, of whom, 417 are living alone*.” If the percentage holds for the remaining refugee population, there would be significantly more older people at risk living alone than were identified in the family counting exercise.

¹⁸⁶ *The Sphere Handbook* (Fourth edition), pp. 113-120. UNHCR has the same global standards, and also calls for latrines to be no closer than six metres to a shelter. See UNHCR, *Emergency Handbook: Camp planning standards (planned settlements)*, <https://emergency.unhcr.org/entry/248797/camp-planning-standards-planned-settlements>

¹⁸⁷ See Reuters, “*Life in the Camps*,” 4 December 2017.

¹⁸⁸ Strategic Executive Group, *Joint Response Plan for Rohingya Humanitarian Crisis: March-December 2018 Final Report*, p. 59 (quoted language and statistic) and p. 17 (phased construction of 55,869 communal latrines to “*incrementally reached a coverage of 20 persons per latrine*”). The Co-Chairs of the Strategic Executive Group are the UN Resident Coordinator in Bangladesh, the Representative of UNHCR Bangladesh, and the Chief of Mission of IOM Bangladesh.

¹⁸⁹ Strategic Executive Group, *Joint Response Plan for Rohingya Humanitarian Crisis: March-December 2018 Final Report*, p. 33.

¹⁹⁰ See *Universal Declaration of Human Rights*, UNGA resolution of 10 December 1948, Preamble and Articles 1, 22; *The Sphere Handbook* (Fourth Edition), p. 29.



Shelters are packed together in the refugee camps, up and down hills. The terrain is difficult for some older people, particularly those with reduced mobility, which brings challenges for accessing latrines, distribution sites, and health facilities, Bangladesh, 20 February 2019. © Reza Rahman / Amnesty International



Abul Hossain, around 85 years old, stands near his shelter in Camp #1 West. He said there was a latrine not too far from his shelter, but the hilly terrain around where he lives at times makes it difficult for him to access the latrine, Bangladesh, 19 February 2019. © Reza Rahman / Amnesty International

RIGHT TO SANITATION

The right to sanitation has been recognized as being derived from the right to an adequate standard of living, and therefore implicitly contained in the ICESCR.¹⁹¹ The right requires that sufficient sanitation facilities, with associated services, be available within, or in the immediate vicinity of, each household, health or educational institution, workplace, public institution, and public place. It requires quality of sanitation facilities, which means they must be hygienically safe to use, including regular cleaning, maintenance, and emptying of pits or other places that collect human excreta. Facilities must be in a safe location and be physically accessible for everyone at all times. Access to sanitation facilities and services must be affordable; ensure privacy and dignity; and be socially and culturally acceptable.¹⁹² The right to sanitation requires special attention to the needs of children, older people, and people with disabilities.

As noted by the Independent Expert on the human rights obligations related to safe drinking water and sanitation, *“Sanitation is not just about health, housing, education, work, gender equality, and the ability to survive. Sanitation, more than many other human rights issue, evokes the concept of human dignity.”*¹⁹³

INACCESSIBLE DUE TO DISTANCE OR LOCATION

Even as camp infrastructure has developed, latrines remain too far or too hard to reach for many older people. The inability to access a latrine is often framed as a major loss of dignity and well-being.

Mawlawi Harun, in his early 90s, told Amnesty International that he was frequently unable to walk the distance to the latrine in his block of Camp #15 and was forced to use a pan inside his shelter instead. *“I go to the latrine here, I eat and sleep here,”* he said. *“I have become like a cow or goat. What more can I say? Cows defecate and urinate in the same place where they eat... Now I’m sleeping in a latrine.”*¹⁹⁴

Some older refugees described being able to walk to the latrine sometimes, when they felt well or strong enough, or were able to get assistance from a family member, but said the distance and terrain made it difficult to reach on all occasions. For example, Kamalun Nisa, around 75 years old, said she tries to walk to the closest latrine from her shelter in Camp #15. *“To get around the camps, it’s not easy,”* she said. *“It takes me around 8 to 10 minutes to walk there... It would be better if the latrine was closer to my shelter—that would make things easier.”*¹⁹⁵ When unable to walk to the latrine, she uses a pan in her shelter.

For others, the distance is too great to ever reach a camp latrine. Zaw Nisa, a 90-year-old woman living in Camp #14, known as Hakimpara, told Amnesty International, *“The latrine is too far [and] on the lower ground. I can’t go there; it’s too far. For now, I go in the corner of my room.”*¹⁹⁶

As mentioned by Zaw Nisa, often the challenge of accessing a latrine is as much or more due to the terrain between the shelter and the latrine as it is due to the distance. Abul Hossain, around 85 years old, who lives in Camp #1 West, said, *“The distance [to the latrine] is not so far, but the problem is that it’s not flat land. I’d have to go up and down the hills... so I just have to do it here... I use [a pan] at home.”*¹⁹⁷

Amnesty International likewise interviewed a 90-year-old man in Camp #11, part of Balukhali 2 Camp, who lives at the end of a narrow drainage path, with dirt-filled rice sacks serving as steep steps to his shelter entrance (see images below). He said there is a latrine near the mosque that is only 50 or so metres from the shelter he shares with his wife, but that it takes him at least 10 to 15 minutes to get there because of the challenge of getting in and out of his shelter. He said that, in late 2018, he fell down when descending the rice sack steps. *“I fell into the shelter across [the path], breaking the bamboo,”* he recalled. *“I hurt my back. There were many women in the shelter [I fell into] who were laughing at me.”*¹⁹⁸

¹⁹¹ Committee on Economic, Social, and Cultural Rights (CESCR), Statement on the Right to Sanitation, 19 November 2010, UN Doc. E/C.12/2010/1, para. 7. The CESCR said the right to sanitation is “integrally related” to the rights to health, housing, and water. See also UN General Assembly, Resolution 68/157: The human right to safe drinking water and sanitation, 18 December 2013, UN Doc. A/RES/68/157.

¹⁹² The criteria used here to describe the right to sanitation are drawn from CESCR, Statement on the Right to Sanitation; and *Report of the UN Independent Expert on the issue of Human Rights Obligations related to Access to Safe Drinking Water and Sanitation*, 1 July 2009, UN Doc. A/HRC/12/24, paras 64-66 and 70-80, https://www.ohchr.org/Documents/Press/IE_2009_report.pdf

¹⁹³ *Report of the UN Independent Expert on the issue of Human Rights Obligations related to Access to Safe Drinking Water and Sanitation*, 1 July 2009, para. 55.

¹⁹⁴ Amnesty International interview, Camp #15 (Jamtoli Camp, Bangladesh), 18 February 2019.

¹⁹⁵ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

¹⁹⁶ Amnesty International interview, Camp #14 (Hakimpara Camp), Bangladesh, 23 February 2019.

¹⁹⁷ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 17 February 2019.

¹⁹⁸ Amnesty International interview, Camp #11 (Balukhali Camp), Bangladesh, 16 February 2019.

The man, who had been a farmer in Myanmar, said he tries to walk to the latrine when possible, but *“if I can't make it there, I go inside the house... I have no choice.”*¹⁹⁹ He said he pays someone to come a few times a week to throw out the waste and clean the pan he uses inside the shelter, giving the person 1,000 taka (US\$12) every two months—stretching his and his wife's already limited resources.²⁰⁰



The path leading to the shelter of the 90-year-old man in Camp #11, Bangladesh, 16 February 2019 © Amnesty International

In response to questions on latrine accessibility, IOM, which has led on site management, said the *“high density in the camps”* as well as many areas being *“highly vulnerable to landslide or flooding”* were limiting factors in choosing locations to install latrines.²⁰¹ Several senior humanitarian workers involved in WASH told Amnesty International that, because of how overstretched the response has been, issues of inclusion—including for older people and people with disabilities—have often not been prioritized.²⁰² The IOM response indicated similarly, noting that *“due to the short timeframe and high demand for WASH services during the initial influx, the WASH unit was not able to meet the requirements of any specific groups' needs,”* focusing instead on *“needs based on the total population in each camps,”* in particular by trying to get latrines installed within 50 metres from households and at least 10 metres from water sources.²⁰³

While Amnesty International recognizes the enormity of the challenges during the first phase of the crisis, camp management and construction, including the installation of latrines, should be guided by principles of inclusivity and non-discrimination from the beginning, to best meet the rights and needs of all people.

In its response, IOM indicated that once the humanitarian situation *“started stabilizing,”* it began constructing or updating latrines to *“semi-permanent gender segregated twin pit latrines to ensure equal access of men and women”*; it said the WASH sector was currently *“working with Site Management and Development to select locations”* for new latrines, though remained constrained by *“limited space and congestion”*.²⁰⁴ It noted the *“WASH sector is preparing a comprehensive roadmap... to ensure inclusion of gender and GBV aspects in WASH interventions.”*²⁰⁵ Those considerations are essential, but the roadmap must also ensure inclusion of older people and people with disabilities.

UNHCR responded similarly, explaining the challenges and priorities during the first part of the crisis and saying it is working to improve access, including by siting new latrines so as to reduce the distance to those

¹⁹⁹ Amnesty International interview, Camp #11 (Balukhali Camp), Bangladesh, 16 February 2019.

²⁰⁰ Amnesty International interview, Camp #11 (Balukhali Camp), Bangladesh, 16 February 2019.

²⁰¹ IOM written response, 30 May 2019, p. 3.

²⁰² Amnesty International interview and telephone interviews, February and March 2019.

²⁰³ IOM written response, 30 May 2019, p. 3.

²⁰⁴ IOM written response, 30 May 2019, p. 3.

²⁰⁵ IOM written response, 30 May 2019, p. 3.

most at risk and by adapting existing WASH facilities to individuals' specific needs. It also said it *"continues to explore more dignified, home-based solutions for the most vulnerable or mobility challenged."*²⁰⁶

Such measures are overdue. Significantly more attention and effort needs to be put toward respecting older people's right to sanitation and ensuring their dignity. New latrines should be built in locations that maximize accessibility for people with limited mobility. When that is not possible, due to the constraints IOM identifies, humanitarian actors should consider other solutions. For example, several older people told Amnesty International they would be interested in moving to another shelter, if it was located on flatter terrain that would make camp services, including latrines, easier to reach.²⁰⁷ IOM indicated that *"efforts are underway to support some relocations to mitigate accessibility challenges,"* though noted space constraints in the camps and the *"reluctance of the concerned individuals and their families to relocate continues to pose challenges."*²⁰⁸ IOM indicated that more could be done to consult with older people in the camps.²⁰⁹

Several older refugees who had gained access to a latrine through recent installation said it was a significant improvement. Hala Balu, around 70 years old, said she and other older people in her block of Camp #1 East had long had to use a pan in their shelter, as the latrine was too far. Several months before being interviewed by Amnesty International in February 2019, a new latrine was installed in a close and accessible location. *"We requested many times, and finally they made a latrine nearby,"* she said. *"It's much better now."*²¹⁰

INSUFFICIENT LIGHTING

The challenging terrain and the distance that some older people have to walk to get to the closest latrine is compounded by the lack of lighting on streets and pathways in many areas of the camps.

A 79-year-old Rohingya former villager leader who lives in Camp #13 said the biggest problems he faces are the lack of access to a latrine and the related lack of lighting: *"It's difficult to get to the latrine at night because of the lack of lighting. [And] to go to the latrines, there is no proper stairway... They're on the ups and downs [of hills]. We need to be able to hold something, but there's not always [something to hold]."*²¹¹

Sayedul Islam, 80, told Amnesty International that, several months earlier, he had tried to walk at night to the latrine in his block of Camp #1 East. *"I fell down and broke a bone in my wrist,"* he said. *"Still now, it hurts."*²¹² His wrist remained swollen when interviewed in February 2019. He said he has to urinate as many 12 times a night and, after falling, uses a pan inside his shelter instead of walking outside.²¹³

Many other older refugees, including those who walk to the latrine without difficulty during the day, similarly raised concerns about the lack of lighting to access latrines at night. Sara Khatun, in her early 70s, said that while during the day she walks on her own to the latrine in five to ten minutes, at night it takes much longer and requires the help of her grandson, because the lack of lighting makes it hard to see the hilly path.²¹⁴

Several humanitarian workers from large international organizations operating in the camps acknowledged that lighting remained limited, but said improvements were made in 2018 and that community committees had been formed to help with maintenance of existing lights.²¹⁵ One of those humanitarian workers said the Bangladeshi authorities indicated in September 2018 that they would take care of camp lighting, after which humanitarian organizations focused efforts elsewhere. The person said there was scant progress in subsequent months, however, and that in early 2019, lighting appeared again in the Joint Response Plan. *"We're not sure if it's actually being handled,"* the humanitarian worker told Amnesty International. *"Either way, it's not clear how consultative the process will be in where lighting [is installed]."*²¹⁶

Among the older refugees interviewed by Amnesty International, lighting was overwhelmingly raised in the context of accessing latrines. But the lack of lighting has a much broader impact on people's rights in the camps, including related to physical well-being. Several humanitarian workers involved in protection monitoring said that many people do not go out of their shelter after dark, as the limited lighting contributes

²⁰⁶ UNHCR written response, 31 May 2019, p. 7. For the complete answer on latrines, see the full response in Annex I.

²⁰⁷ Amnesty International interviews, Bangladesh, February 2019.

²⁰⁸ IOM written response, 30 May 2019, p. 2.

²⁰⁹ IOM written response, 30 May 2019, p. 2.

²¹⁰ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 19 February 2019.

²¹¹ Amnesty International interview, Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

²¹² Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 21 February 2019.

²¹³ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 21 February 2019.

²¹⁴ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 19 February 2019.

²¹⁵ Amnesty International interviews, Cox's Bazar, Bangladesh, February 2019.

²¹⁶ Amnesty International interview, Cox's Bazar, Bangladesh, 22 February 2019.

to, as one person described it, a “precarious” security situation.²¹⁷ Better lighting would have a much broader impact on the rights and well-being of everyone, including older people, in the camps.

In its response to Amnesty International, IOM wrote that in 2018 it had “installed 2200 solar lights including near latrines” and that in 2019 more solar lights would be installed through funding from the Asian Development Bank (ADB), adding, “The prioritization of the locations to be targeted by solar street lights was made in consultation with communities and the Site Management Sector and agencies.”²¹⁸ For the camps it manages, UNHCR referenced the installation of 900 solar street lights to date, with plans for further installation.²¹⁹ Both agencies also highlighted the extensive distribution of portable lights to households.

These developments are notable, but Amnesty International’s interviews indicate that many older people continue to not have adequate access to a latrine at night because of the limited reach of lighting.

LATRINE DESIGN

While older people overwhelmingly spoke of the challenge of getting to a latrine as their main access constraint, several also mentioned the design of the latrines. This was particularly an issue for people with disabilities that affected the use of their legs. Latrines in the camps have been built by UN agencies, national and international humanitarian organizations, and by refugees themselves, which has resulted in varied quality; although there was significant improvement in 2018, some still do not meet UNHCR standards and many do not have features that would improve accessibility for older people and people with disabilities.²²⁰

Laila Khatun, around 85 years old, said she had been unable to walk for the last four or five years, due to a broken back. She was unable to go by herself to the latrines in her area of Camp #1 East and said that, even if her children assisted her in getting to one, she couldn’t physically use them.²²¹ Most camp latrines are a concrete block with a hole in the ground—and nothing to hold on to. Laila Khatun said she instead uses a pan inside her shelter and that her children occasionally clean it for her.²²²

In some camps, there have been efforts to make latrines more inclusive. Mohammed Jaberul Hoque, Coordinator for Resource Integration Centre (RIC), which helps run Age Friendly Spaces in several camps, showed Amnesty International a design for an inclusive latrine involving a rope and handle that allows people to hold themselves steady and then pull themselves up; and a plastic latrine chair that allows people to sit instead of squat using their own strength (see images below).

Hoque said that in Camp #18, one of three camps where RIC operates as an implementing partner for HelpAge International, RIC has worked with WASH partners to add support handles to hundreds of latrines and to provide 45 chair latrines in locations identified based on people’s needs.²²³



Latrines with a rope handle and plastic latrine chair, Camp #18 Age Friendly Space, Bangladesh, 23 February 2019 © Reza Rahman / Amnesty International

²¹⁷ Amnesty International telephone interview, March 2019. The person also noted that protection monitoring is almost non-existent after 4 p.m., when humanitarian staff have to leave the camps, under rules from the Bangladesh authorities related to aid workers’ security.

²¹⁸ IOM written response, 30 May 2019, p. 4.

²¹⁹ UNHCR written response, 31 May 2019, p. 7.

²²⁰ Amnesty International interviews, Cox’s Bazar, Bangladesh, February 2019. See also Reuters, “Life in the Camps”.

²²¹ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 17 February 2019.

²²² Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 17 February 2019.

²²³ Amnesty International interview, Age Friendly Space in Camp #18, Bangladesh, 23 February 2019.

The Bangladesh country director of an international humanitarian organization told Amnesty International that implementing these changes costs about three US dollars per latrine. “Three dollars... that’s it,” she said. “And the design [that benefits older people] is universal. Pregnant women benefit. People with spinal cord and other injuries benefit.”²²⁴ The more inclusive design has been implemented in several camps, in particular where HelpAge International and its local partners operate, but, more than 21 months after the crisis’s outbreak, is not systematic throughout all camps.

LACK OF PRIVACY OF BATHING FACILITIES

None of the older women interviewed by Amnesty International reported using the camp bathing facilities. In addition to distance and terrain challenges, older women said they could not use bathing facilities because of a lack of privacy. A December 2018 survey analysis shows this is a widespread problem for women in the camps, and that “the most common access barrier is the lack of gender separation in bathing spaces”.²²⁵

In order to protect their privacy, many women in the camps have built their own makeshift bathing facilities inside their shelters. Older women, however, are at times not able to build the same for themselves and have to rely on the bathing arrangements that their relatives have made inside their shelters.

For example, Kamalun Nisa, around 75 years old, told Amnesty International that the camp bathing facility was too far away and that “women can’t go there, only men. We need privacy.”²²⁶ She said her daughters-in-law had made their own makeshift bathing facility in their shelter nearby, which she tried to use when she was able to walk there and it was not already occupied.²²⁷

3.2 HEALTH SERVICES

With more than 910,000 Rohingya refugees packed into 34 camps, humanitarian health providers are tasked with providing care for a mid-size city. During the crisis’s first months, as the Myanmar military attacked and burned villages, camp hospitals in Bangladesh treated hundreds of Rohingya women, men, and children arriving with violence-related injuries, including gunshot wounds, stab wounds, burns, and blunt trauma.²²⁸ In subsequent months, the military’s forced starvation tactics, on top of an apartheid regime that already undermined access to food and livelihoods, meant many more arrived to Bangladesh malnourished, including with severe acute malnutrition.²²⁹ Medical providers have also needed to undertake massive vaccination efforts, as many Rohingya were denied such care in Myanmar, putting the refugee camps at risk of outbreaks of diseases like cholera.²³⁰ For these efforts, and many more, the emergency health response in the Bangladesh refugee camps has been impressive, saving many lives.

But, more than 21 months after the crisis’s outbreak, camp health services are not respecting many older people’s right to health and are falling short of humanitarian principles of inclusivity and the right to dignity.²³¹ The health response remains overwhelmingly centre-based, which means that, to see a health worker and receive treatment, people need to get to a health facility, of which, at the end of 2018, there were around 200, including 10 hospitals, spread across the camps.²³² The centre-based approach, as opposed to a more mobile approach in which people with specific needs would be treated at or near their shelter, does not meet the rights and needs of many older women and men, in particular those with limited or no mobility, who cannot access clinics due to their distance or the hilly terrain.

²²⁴ Amnesty International interview, Dhaka, Bangladesh, February 2019.

²²⁵ ACAPS & NPM Analysis Hub, *Rohingya Influx Overview (RIO) – December 2018*, p. 5, <https://bit.ly/2Mr00j7>

²²⁶ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

²²⁷ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

²²⁸ See MSF, *No One Was Left”: Death and Violence against the Rohingya in Rakhine State*, Myanmar, 9 March 2018, pp. 11-12; Amnesty International, “We Will Destroy Everything”.

²²⁹ See Amnesty International, “We Will Destroy Everything”, pp. 101-111.

²³⁰ See, for example, UNICEF, “One million Rohingya refugees, host communities being vaccinated against cholera,” 6 May 2018, <https://www.unicef.org/bangladesh/en/press-releases/one-million-rohingya-refugees-host-communities-being-vaccinated-against-cholera>

²³¹ ICESCR, Article 12; WHS, *Commitments to Action* (Core Responsibility 3); ADCAP, *Humanitarian inclusion standards for older people and people with disabilities*.

²³² Strategic Executive Group, *Joint Response Plan for Rohingya Humanitarian Crisis: March-December 2018 Final Report*, pp. 26-28, 57.

Even when older people can physically reach a clinic, they often find it does not have medication for common chronic conditions that disproportionately affect older people, such as high blood pressure, chronic pain, and chronic respiratory disease. This problem is not unique to the health response in the Bangladesh refugee camps; it is recurrent in humanitarian crises.²³³

Due to camp clinics' inaccessibility and inability, in some cases, to provide essential medication, a majority of the older refugees interviewed by Amnesty International said that, even when living with a chronic condition, they do not go to such clinics regularly, or, for some people, ever. Instead, they are forced to send family members to camp markets to buy essential medication. Many older people are unable to pay for such medication, or at least to do so regularly, according to their needs. Others are forced to sell part of their food ration or other items—negatively impacting their physical and mental health in other ways.

RIGHT TO HEALTH

Article 12 of the ICESCR recognizes the *“right of everyone to the enjoyment of the highest attainable standard of physical and mental health”*.²³⁴

In General Comment 14, the Committee on Economic, Social, and Cultural Rights (CESCR), the UN expert body that monitors the ICESCR's implementation, recognised the right to health as *“an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information... A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.”*²³⁵

The right to health requires that health care facilities, goods, and services be available in sufficient quantity; be accessible to everyone without discrimination, which includes affordability, information accessibility, and physical accessibility, such as for older people and people with disabilities; be acceptable to all persons, that is, respectful of medical ethics and culturally appropriate; and be of good quality.²³⁶ The right to health of older people, in line with CESCR General Comment 6, reaffirms the importance of an integrated approach, combining preventive, curative, and rehabilitative health treatment.

INACCESSIBLE CAMP CLINICS

Many older women and men are unable to access camp clinics, primarily due to the same terrain challenges that hinder access to latrines (see section 3.1, above). The distance to camp clinics tends to be even further than to latrines. Long queues and the need to return regularly for medication refills add further problems.

Zaw Nisa, around 90 years old, said she lives with chronic gastric pain and often gets diarrhoea; to walk to the nearest camp hospital in Camp #14, she said it took her about an hour, using a walking stick.²³⁷ Abul Hossain, around 85 years old, said he needs to take medicine for recurrent urinary problems and other conditions; to get to the closest camp clinic in Camp #1 West, he said it took *“half a day. I can't go there independently... I have to stop frequently. I get tired.”*²³⁸ Both Zaw Nisa and Abul Hossain said the difficulty of walking to the clinic meant they typically avoided going, even when ill, instead relying on family members to purchase medication from camp market stalls (see section below).

Several older people with limited mobility said it would be prohibitive to reach even the closest camp clinic on foot, and so have to pay for transport. Johara Begum, 65, explained, *“It takes a long time to get to the hospital. On foot, I can't go. By vehicle, I can go quickly, but we would need to rent the vehicle—sometimes it's 20 taka (US\$0.25), sometimes 15 taka.”*²³⁹ (For another example, see Sokhina Khatun's profile, on page 16.) While 20 taka may seem insignificant, many Rohingya families fled Myanmar with no money or

²³³ Amnesty International interviews with senior humanitarian workers and experts on older people in emergencies, Cox's Bazar, Bangladesh, and New York, United States, February 2019 and May 2019; and telephone interviews, November 2018 and January 2019. See also, for example, HelpAge International, *Health interventions for older people in emergencies*, pp. 6, 15, 19-20; HelpAge International, *Older people in emergencies identifying and reducing risks*, p. 10.

²³⁴ ICESCR, Article 12.

²³⁵ CESCR, General Comment No. 14: The right to the highest attainable standard of health (Art. 12), 11 August 2000, UN Doc. E/C.12/2000/4, para. 11.

²³⁶ CESCR, General Comment No. 14: The right to the highest attainable standard of health (Art. 12), para. 12.

²³⁷ Amnesty International interview, Camp #14 (Hakimpara Camp), Bangladesh, 23 February 2019.

²³⁸ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 17 February 2019.

²³⁹ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 17 February 2019.

valuables and, in Bangladesh, are not allowed to seek work, giving them no way to earn money. Twenty taka spent to travel to a camp clinic is 20 taka taken from fulfilling another critical need.

The situation is worse for older women and men who are shelter-bound, generally due to severe physical disabilities. An 85-year-old woman in Camp #11 with a physical disability that left her unable to walk said she could not go to a camp clinic because of her disability; she relies on her grandson to purchase medication.²⁴⁰ A 90-year-old woman in Camp #1 East recounted similarly that she had been unable to walk for several years due to a physical disability and could therefore only go outside her shelter when her children or grandchildren carried her. She said she needed to take medication regularly for a variety of health problems but was unable to go to a camp clinic.²⁴¹ One of her sons, also interviewed by Amnesty International, said he purchases medication for his mother in the market, as it is too difficult for him to carry her to the camp clinic and, if he did, they would have to wait together for a long time in the queue.²⁴²

Many older people said long queues at camp clinics compound their inaccessibility. A 90-year-old man in Camp #1 East said he needed to take medication daily, including for high blood pressure. To get to the closest clinic, *“it takes me two hours,”* he said. *“My children carry me there. Then I have to wait in the queue for a long time.”*²⁴³ Due to the difficulty of getting to the camp clinic and the long queue, the man said he rarely went, and instead had his children purchase medication from a camp market.²⁴⁴

For Kamalun Nisa, around 75 years old, in Camp #15, the long queues meant she stopped going to camp clinics: *“I am only alive because of the medicines [I take]... [Before] when I fell sick, I went to the camp clinic many times and had to wait the whole day, so now I don't go... I buy medicines in the market.”*²⁴⁵

Long queues at camp clinics undoubtedly reflect the enormous needs in the camps. Several international humanitarian workers said the health response is particularly overstretched.²⁴⁶ Medical professionals are best placed to undertake triage; the prioritization of patient treatment is not at issue in this report. What is, however, is the right of older people to access health services. Many older people, and in particular older people with limited or no mobility, require assistance in reaching and queuing at a camp clinic; someone else must be willing to spend her or his day in the queue, not just the person seeking treatment. To mitigate this, camp health providers could, for example, expand existing networks of community volunteers in the camps to have someone sit with older people in queues and help them return to their shelter. Or mobile health teams could reach people with limited mobility or who are shelter-bound in or near their shelters.

Health services are inaccessible to many people because they remain rooted in a centre-based response in which those in need of health care must get to a clinic. The main exception is in the six camps where HelpAge International operates, where, in addition to a doctor and a paramedic who see patients at the Age Friendly Spaces, there is a second paramedic who does shelter visits.²⁴⁷ Those efforts provide an important model, but are insufficient, even in those six camps, to meet the needs of all older people who require shelter-based care. Outside of those six camps, Amnesty International did not interview a single older person who had been seen or treated by a health professional in her or his shelter.

In its written response, IOM, which runs and supports camp clinics, said its approach has been to create *“static health facilities while ensuring that the facilities are within 30mins reach for more than 80% of the users in the catchment area... This approach also allowed IOM to continue to provide more comprehensive and specific services... which improved the quality of care and reduced referral needs; that would have not been possible with Mobile Response Teams approach.”*²⁴⁸ Improving quality of care is critical, but IOM's statistics bear out that, for a significant number of people, static facilities are not readily accessible. As Amnesty International's interviews show, those being left out appear disproportionately to be older people and people with disabilities, who face specific risks and have particular needs that are not being met.

IOM said that it sees mobile response teams *“play a key role [in] expanding coverage and reaching specific needs, so options are being evaluated to consider”* having such teams complement static facilities.²⁴⁹ It also said there was a *“network of 350 Community Health Workers”* who go shelter to shelter and *“help identify*

²⁴⁰ Amnesty International interview, Camp #11 (Balukhali 2 Camp), Bangladesh, 16 February 2019.

²⁴¹ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 17 February 2019.

²⁴² Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 17 February 2019.

²⁴³ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 17 February 2019.

²⁴⁴ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 17 February 2019.

²⁴⁵ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

²⁴⁶ Amnesty International interviews, Cox's Bazar, Bangladesh, February 2019.

²⁴⁷ Amnesty International interview, Mohammed Jaberul Haque, Coordinator of RIC, Camp #18, Bangladesh, 23 February 2019.

²⁴⁸ IOM written response, 30 May 2019, p. 5.

²⁴⁹ IOM written response, 30 May 2019, p. 5.

shelter bound individuals in need of medical services and coordinate with [a] nearby health facility.”²⁵⁰ UNHCR said that to help people with disabilities get to health posts, there were also ambulances, support for three-wheelers, and porters.²⁵¹ These are important initiatives, but, as noted above, aside from the areas where HelpAge operates, none of the older people interviewed by Amnesty International, including those with limited mobility or who are shelter-bound, said they had been so assisted; each person was asked.

A senior humanitarian worker in Cox’s Bazar recognized that the health response had been too “centre-based” and said there were “efforts now toward mobile clinics,” though described them as primarily being mobile from “camp to camp, not shelter to shelter.”²⁵² If, in selecting their locations, mobile clinics take into specific consideration the needs of people with limited mobility, including older people with limited mobility, they will improve access. However, older people with disabilities, including those who are shelter-bound, are likely to continue to get left behind, without greater efforts to meet their needs. To meet those needs, health actors must ensure all such people are identified through shelter-to-shelter assessments.

For people who take daily medication for chronic diseases, such as for high-blood pressure or diabetes, the problems with a centre-based approach also manifest in the need to return to a clinic every few days for a new supply of medication. Mohamed Toyub, 63, said he had to go every 10 days to his clinic in Camp #8 to get a new supply of medication for his high blood pressure.²⁵³ Fatima, 55, said she has to collect a new supply of her high blood pressure medication every three days from another clinic in Camp #18.²⁵⁴ While they, and a few other older women and men interviewed by Amnesty International, were able to walk to clinics when necessary, for older people with limited mobility, this is impossible.

UNEVEN QUALITY OF CLINICS, LIMITED REFERRAL SYSTEM

Among older people who can access camp clinics, there were starkly different descriptions of the clinics’ ability to respond to their health needs. The most common concern was that some clinics lack medication and other services to treat chronic conditions that disproportionately affect older people. Compounding the situation, the referral system among camp clinics and to outside hospitals appears limited and ineffective.

Some older Rohingya women and men spoke highly of the care they received at camp clinics; in Amnesty International’s interviews, specific mention was made of clinics associated with the Age Friendly Spaces run by HelpAge, of the Friendship Hospital in Kutupalong Camp, and of IOM clinics.

More often, older people expressed frustration not just with clinics’ physical accessibility and long queues, but with the treatment provided. This was less the case for infectious diseases; most older people said they received oral antibiotics when they went to clinics with high fevers and diarrhoea.²⁵⁵ But in the treatment of chronic conditions, some camp clinics appear ill-equipped.

Several dozen older women and men interviewed by Amnesty International described going to clinics for chronic conditions—including high blood pressure, chronic respiratory illness, and chronic pain—and receiving a few paracetamol tablets or nothing. Several recounted being told explicitly at a camp clinic that it was out of relevant medication.²⁵⁶ This often led older people to stop visiting camp clinics and forced them to buy essential medication from unregulated markets. Hala Banu, around 70 years old, told Amnesty International that she needed to take medication for chronic gastric problems and heartburn, among other conditions. “I went two or three times [to the camp clinic],” she said. “I had to wait very long there, and they only gave me two or three tablets... Why should I walk so far for a couple tablets? One of my sons is working in the camp. When he gets paid, he helps buy the medications for me.”²⁵⁷ She said they spent around 5,000 taka (US\$59) per month for her medication, which was only possible because of her son’s job.²⁵⁸

²⁵⁰ IOM written response, 30 May 2019, p. 5. In its written response, UNHCR likewise referenced the role of the 350 community health volunteers, as well as of community outreach members (COMs), who it said “are also engaged in identifying, referring, and transporting refugees with physical mobility challenges to health services.” UNHCR written response, p. 11.

²⁵¹ UNHCR written response, 31 May 2019, p. 10.

²⁵² Amnesty International interview, Cox’s Bazar, Bangladesh, 22 February 2019.

²⁵³ Amnesty International interview, Camp #8 (Balukhali Camp), 22 February 2019.

²⁵⁴ Amnesty International interview, Camp #18, 23 February 2019.

²⁵⁵ Amnesty International interviews, Bangladesh refugee camps, February 2019.

²⁵⁶ Amnesty International interviews, Bangladesh refugee camps, February 2019.

²⁵⁷ Amnesty International interview, Camp #1 East (Kutupalong Camp), 19 February 2019.

²⁵⁸ Amnesty International interview, Camp #1 East (Kutupalong Camp), 19 February 2019.



Hala Banu, around 70, sits in her shelter in a refugee camp in Bangladesh, 19 February 2019. © Reza Rahman / Amnesty International

Johara Begum, 65, said she needed to take daily medication for high blood pressure and chronic pain, but that, for the clinics near her in Camp #1 West, “they never give that type of medicine—just two to four tablets for fever or for stomach pain.”²⁵⁹ She said her children went to the market to buy medication for her conditions, paying around 4,000 taka (US\$47) per month.²⁶⁰

The failings are not universal. Some camp clinics carry medication for chronic diseases; Amnesty International interviewed older women and men who received high blood pressure medication and treatments for chronic respiratory illness from HelpAge and IOM-run clinics.²⁶¹ Kobir Ahmed, 63, said he received medication for diabetes from a clinic run by Small Kindness Bangladesh (SKB), though added that the clinic had once closed unexpectedly for a month, leaving him unable to get the pills.²⁶² But there is not a requirement that all health providers operating camp clinics will stock medication for even common chronic diseases, many of which older women and men suffer from disproportionately.

Inadequate treatment of chronic diseases is a recurrent problem in humanitarian response, particularly during the early stages, despite the fact that it is one of the leading causes of death worldwide and, when untreated, has a cascade of negative effects, including by limiting mobility and activity more generally.²⁶³

²⁵⁹ Amnesty International interview, Camp #1 West (Kutupalong Camp), 17 February 2019.

²⁶⁰ Amnesty International interview, Camp #1 West (Kutupalong Camp), 17 February 2019.

²⁶¹ Consistent with the positive statements about IOM clinics, IOM’s written response indicated that its clinics provide health services that include supplies, medication, and equipment for treating, among other things, chronic diseases, and that their warehouse storage system allows for “timely replenishment” so that medication remains in stock. IOM written response, 30 May 2019, p. 4.

²⁶² Amnesty International interview, Camp #15 (Jamtoli Camp), 15 February 2019.

²⁶³ Amnesty International interviews with senior humanitarian workers and experts on older people in emergencies, Cox’s Bazar, Bangladesh, and New York, United States, February 2019 and May 2019; and telephone interviews, November 2018 and January 2019. See also HelpAge International, *Health interventions for older people in emergencies*, pp. 6, 19-20; HPG and HelpAge International, *Older people in displacement: Falling through the cracks of emergency responses*, p. 20; and WHO, *Older people in emergencies: Considerations for action and policy development*, 2008, pp. 5-6.

In its response, UNHCR said the Health Sector had developed a document called the *Minimum Essential Package for Essential Health Services*.²⁶⁴ It said the document calls for those who run health posts and primary health care centres to have treatment and care for chronic diseases, also referred to as non-communicable diseases (NCDs), but said that as the sector “*is in a transition phase from emergency to protracted, the level of implementation of NCD care... varies from partner to partner.*”²⁶⁵

Some health actors’ continued lack of care for chronic diseases, more than 21 months into the crisis, does not respect older people’s rights or meet core humanitarian principles. Indeed, humanitarian actors involved in health response, including donor governments who provide funding, should consider care for chronic conditions as part of emergency response—not simply the “protracted” phase. Assessments from the beginning of a humanitarian emergency should identify the needs of the relevant population in terms of chronic conditions and ensure there are health providers equipped to respond—and that the system as a whole can identify and reach those in need of such care.

Among the humanitarian community in Cox’s Bazar, there is recognition of the health sector’s uneven quality. A senior humanitarian worker told Amnesty International that “*there are some camps with too many clinics of bad quality*”; the aid worker said there was a “*rationalization plan under way*” that would eliminate some low-quality clinics.²⁶⁶ The March 2019 Health Sector Bulletin for the refugee response in Bangladesh indicates that the rationalization plan will “*reduce duplication of health services... free up land for shelters and road infrastructure projects*” and “*provide higher quality services*” by ensuring minimum standards.²⁶⁷ The process seems likely to improve care for people, including older people, who can access clinics. However, it does not appear to address the challenges of reaching a clinic in the first place; indeed, reducing the number of clinics will mean some older people have to walk further and likely wait longer.

Even absent a requirement for camp clinics to be able to provide appropriate treatment for common chronic conditions, the problems could have been mitigated earlier if there was a well-designed and implemented system for transporting people with specific needs to appropriate clinics. That does not appear to exist. No older person interviewed by Amnesty International had been provided or reimbursed for transport to a camp clinic; several had paid for their own transport. Nor, when older people reached a clinic that could not provide adequate care, were they transported or provided a voucher for transport to another clinic that, for example, had better diagnostic equipment or a supply of relevant medication.

While people without mobility limitations can, and do, walk from camp clinic to camp clinic in search of better treatment, that is not feasible for many older women and men. As a result, whether an older person gets appropriate treatment for a chronic disease is primarily a question of luck: luck in where she or he set up shelter initially, and in what health provider runs the nearest clinic.

In theory, when camp health providers do not have the capacity to treat someone, a referral system is in place with local Bangladesh hospitals. In practice, this works poorly, and in only the most extreme cases. Bangladesh restricts refugees from leaving the camp areas absent specific approval, such as permission to get medical treatment, and the security forces operate checkpoints near the camps to monitor movement.

A 65-year-old man in Camp #1 East told Amnesty International that he often could not urinate and experienced severe pain as a result; he said a camp clinic doctor told him that he needed to go to a hospital in Cox’s Bazar for an operation. He was given no referral paperwork, or even information about the referral process, and said he could not go for the operation because “*I don’t have the money to pay for it,*”²⁶⁸—even though, under the referral system, payment should not be necessary.²⁶⁹

Two women with Hepatitis C, one who was 60 years old and another who was 50, similarly recounted camp doctors telling them they needed to go to hospitals outside the camp, but said they were not given a referral document or permission letter, which meant they would not be able to get past checkpoints; one of them had tried anyways, but said the Bangladesh security forces stopped her at a checkpoint and sent her back to the camp.²⁷⁰ Several older men, including one whose arm had become paralyzed, also described being

²⁶⁴ UNHCR written response, 31 May 2019, p. 9. In prior correspondence, UNHCR said the *Essential Health Service Package* for the refugee camps “*has been promoted since the start of 2019*”. Correspondence on file with Amnesty International.

²⁶⁵ UNHCR written response, 31 May 2019, p. 9.

²⁶⁶ Amnesty International interview, Cox’s Bazar, Bangladesh, 22 February 2019.

²⁶⁷ WHO, Rohingya Crisis in Cox’s Bazar District, Bangladesh: Health Sector Bulletin #8, 22 March 2019, <http://www.searo.who.int/bangladesh/health-sector-cxb-bangladesh-no8.pdf>, p. 4.

²⁶⁸ Amnesty International interview, Camp #1 East (Kutupalong Camp), 21 February 2019.

²⁶⁹ Amnesty International interview with senior humanitarian workers, Cox’s Bazar, Bangladesh, February 2019.

²⁷⁰ Amnesty International focus group interview, Kutupalong Camp, Bangladesh, 19 February 2019. A camp medical provider in Bangladesh confirmed that they did not treat Hepatitis C at camp clinics. Amnesty International interview, February 2019.

turned back at checkpoints when trying to get to hospitals in Cox's Bazar.²⁷¹ At the time of the interview, all of them had given up on the process and never accessed a hospital outside the camps.

There is recognition among the humanitarian community that the referral system does not meet existing needs. The March 2019 Health Sector Bulletin notes that to “reduce avoidable deaths, much work is needed to improve the referrals systems.”²⁷² IOM, while relating it had managed 11,000 referrals since the crisis began, said the “movement of refugees in/out of the camps is controlled by the local camp administrators... Although acute medical emergencies are waived of this prior permission, this is not the universal norm. There are frequent instances where lifesaving referrals are delayed because of the need for approval.”²⁷³

Several humanitarian workers said the problems are in part due to Bangladesh's health services, like those in the camps, being overstretched. A senior humanitarian worker involved in the health sector told Amnesty International, “Those who may not find appropriate medication or services in the camp could be referred to the district hospital in Cox's Bazar—through a lengthy and not always clear process. We've been doing this for surgery... But we are confronted with a saturation of services that's also affecting local communities.”²⁷⁴ UNHCR's written response to Amnesty International indicated similarly.²⁷⁵

While the saturation affects all groups in the camps, and means that many refugees' rights are not being respected, it seems likely that older people are affected disproportionately—given their relative invisibility and their difficulty in accessing even the first stage of an overly centre-based system.

NEED TO PURCHASE MEDICATION FROM MARKET STALLS

Almost every older woman and man interviewed by Amnesty International said she or he purchased medication or vitamin supplements from market stalls—most often from markets inside the camps, less commonly from local markets on the main road by the camps. Some purchases are undoubtedly made without a medically-supported basis or benefit; these do not reflect on the humanitarian response's supply of medication, but are still often a consequence of health services' inaccessibility—which pushes older people to self-medicate. Other purchases are a result of camp clinics not having medication disproportionately needed by older people, including for high blood pressure, diabetes, and chronic respiratory illness. Buying medication from the market is expensive, forcing some older people to sell food and other items.

Sayedul Islam, 80, said he suffered from a variety of chronic conditions, including gastric pain, dizziness, and high blood pressure. He went often to clinics in Camp #1 East and said he was given medication for several days. “After taking the medication, I feel better for a few days,” he said. “But when the medications are finished, I feel worse again.”²⁷⁶ The clinics near him did not have medication to treat his high blood pressure, so he purchased it in the market, spending 3,000 to 4,000 taka (US\$35-\$47) every two months.²⁷⁷

A 90-year-old man in Camp #11 said he spends about 1,500 taka (US\$18) per month for a variety of medications, including to treat his high blood pressure; without them, “it becomes difficult for me to move,” he said.²⁷⁸ Nur Mohammed, 70, in Camp #8 East, said he spends 600 to 700 taka per month (US\$7-\$8) for medication to help deal with chronic pain in his knees and legs; his mobility becomes far more limited without it.²⁷⁹ Mohammed Ilyas, 62, in Camp #1 East, said he spends around 300 to 500 taka (US\$3.50-\$6) per month to purchase medication in the market to treat his asthma.²⁸⁰

Some older people rely on adult children or grandchildren to pay for essential medications; they said some of those children and grandchildren work for humanitarian organizations in the camps, or pick up odd jobs when available. When there were gaps, or other expenses deemed more pressing by the family, older people have to forego their medication. A 42-year-old man in Camp #1 West said he often needed to take his father, in his 80s, to a market pharmacy to get medication to treat a variety of health issues, including a recurring urinary problem. “Sometimes I need to take him, but I don't have money so can't,” the man said.²⁸¹

²⁷¹ Amnesty International focus group interview, Camp #15 (Jamtoli Camp), Bangladesh, 16 February 2019.

²⁷² See WHO, Rohingya Crisis in Cox's Bazar District, Bangladesh: Health Sector Bulletin #8, p. 5.

²⁷³ IOM written response, 30 May 2019, p. 5. For more information from IOM on the referral system, see the full letter in Annex II.

²⁷⁴ Amnesty International telephone interview, March 2019.

²⁷⁵ UNHCR written response, 31 May 2019, p. 10.

²⁷⁶ Amnesty International interview, Camp #1 East (Kutupalong Camp), 21 February 2019.

²⁷⁷ Amnesty International interview, Camp #1 East (Kutupalong Camp), 21 February 2019.

²⁷⁸ Amnesty International interview, Camp #11 (Balukhali 2 Camp), 16 February 2019.

²⁷⁹ Amnesty International interview, Camp #8 East (Balukhali Camp), 16 February 2019.

²⁸⁰ Amnesty International interview, Camp #1 East (Kutupalong Camp), 21 February 2019.

²⁸¹ Amnesty International interview, Camp #1 West (Kutupalong Camp), 17 February 2019.

For other older people, including those who live alone or who have adult children unable to work, the situation is worse. Several said they went without medication beyond what they could get from a camp clinic and just suffered. Many others described selling parts of their food ration or essential non-food items.

For example, Mostaba Khatun, 55, said her husband had limited mobility as a result of chronic, severe pain in his left side; she said the problem began in Myanmar, but has become much worse since fleeing to Bangladesh. She said that when her husband went to camp clinics near their shelter in Camp #8 East, they gave paracetamols or said they had no medication for him. Mostaba Khatun's husband found relief from the pain by taking, two to three times a month, a 500-taka (US\$6) injection that her nephew, who had been a local doctor in Myanmar, purchased from the market. *"We have no income or anything, so sometimes we sell our [food] ration to get the money for the treatment my husband needs,"* she said.²⁸²

Gul Bahar, around 80 years old, said she needed to spend around 5,000 taka (US\$59) per month on medication, including pills for her high blood pressure and injections to treat her severe asthma. She said that when she went to camp clinics near her in Camp #14, she was generally given paracetamol. She lived with an adult son who was unable to take odd jobs around the camps to earn money, as he had been shelter-bound for a month due to a severe stomach ailment. To pay for her medications, *"we sell this and that,"* Gul Bahar said. *"We sell part of our food ration and cooking oil. We also sold our blankets."*²⁸³

Having to sell blankets or food to pay for medication that should be standard in a humanitarian response undermines older people's rights to food and to physical and mental health. It forces them to choose between what should be basic assistance. It also reflects just how invisible older people remain in the Bangladesh camps, and how secondary their rights are often treated.

3.3 FOOD AND WATER

As hundreds of thousands of Rohingya women, men, and children fled to Bangladesh in a matter of weeks, a tarpaulin city emerged near-overnight in an area where there used to be forest. Cox's Bazar District has poor road infrastructure and no port, making large-scale import and transport of food and other essential items a logistical challenge. Complicating matters further, the Myanmar authorities have long persecuted the Rohingya, including by restricting access to livelihoods and food, which meant there was a high percentage of people suffering from malnutrition before the deportation to Bangladesh.²⁸⁴

But, despite the overall challenges, the humanitarian response has insufficiently taken into consideration the specific needs of older people in terms of accessing adequate food and water. That begins with the delays in individual registration and with other problems of inadequately inclusive data collection and analysis (see text box on page 36), which has left older people, and their specific nutritional needs, largely invisible.

More than 21 months into the refugee crisis, most older people are surviving on a diet that poses particular risks to their health and well-being. Food distribution centres, water points, and cooking material also remain difficult, if not impossible, for many older people to reach. Older people who live alone or as the head of a household find themselves in a particularly difficult situation. Compounding the problems, humanitarian actors have at times been ineffective in informing, much less consulting with, refugees about changes to the food distribution or about how to resolve problems like a family member not being included on a distribution list, which has a disparate impact on older women and men.

As a result, older refugees' rights have been undermined with respect to adequate food and water as well as to physical and mental health.²⁸⁵ Older people's unequal access to food and water, and the lack of effective action to address it, also falls short of humanitarian principles of inclusivity and non-discrimination.

²⁸² Amnesty International interview, Camp #8 East (Balukhali Camp), 16 February 2019. She said they had asked at the camp clinics whether they had the injection her husband used, and they said no. She also said the camp clinics had never referred her husband for examination at a hospital outside of the camps. Amnesty International interview, Camp #8 East (Balukhali Camp), 16 February 2019.

²⁸³ Amnesty International interview, Camp #14 (Hakimpara Camp), 23 February 2019.

²⁸⁴ For more on food insecurity and malnutrition prior to the 2017 crisis, see Amnesty International, *"Caged without a Roof"*, pp. 77-79.

²⁸⁵ ICESCR, Articles 11 and 12. See also CESCR, General Comment 15: The right to water, UN Doc. E/C.12/2002/11; UN Human Rights Council, Resolution 15/9: Human rights and access to safe drinking water and sanitation, 2010; and UN General Assembly, Resolution 68/157: The human right to safe drinking water and sanitation, 2013.

RIGHTS TO FOOD AND WATER

Article 11.1 of the ICESCR recognizes “the right of everyone to an adequate standard of living for himself and his family, including adequate food... and to the continuous improvement of living conditions,” and article 11.2 recognizes “the fundamental right of everyone to be free from hunger”.²⁸⁶

In General Comment 12, the CESCR highlighted that the right to food requires the state to ensure availability of adequate food either from cultivable land or other natural resources, or from distribution and market systems. The right to food further requires that food be affordable and accessible to all, including those who are discriminated against or who face barriers or risks in obtaining adequate food, with specific reference made to older people. It also requires that food be of sufficient quantity and quality to meet the nutritional needs of individuals, and be culturally acceptable.²⁸⁷

The right to water has been recognized as being derived from the right to an adequate standard of living, and therefore implicitly contained in the ICESCR and other instruments.²⁸⁸ The right to water includes the availability of sufficient water for personal and domestic uses, including for drinking, personal sanitation, washing of clothes, food preparation, and personal and household hygiene.²⁸⁹

According to CESCR General Comment 15, water and related facilities and services must be within safe physical reach for all sections of the population, within or in the immediate vicinity of each household, educational institution, and workplace. Water facilities and services must provide affordable, safe water and “be sensitive to gender, life-cycle, and privacy requirements”.²⁹⁰ The CESCR calls on state parties to take steps to ensure that those facing difficulties with physical access to water, such as older people and people with disabilities, are provided with sufficient and safe water.²⁹¹

INADEQUATE NUTRITION

The in-kind food distribution in the Bangladesh refugee camps consists of rice, oil, and lentils, the amount of each of which is based on the number of family members on a household card. Many older women and men—and people in the camps more generally—expressed concern about the limited diet.

For example, a 70-year-old former civil servant in Myanmar, who lives in Camp #1 West, told Amnesty International, “We are getting food, but it’s insufficient. Sometimes we need fish or meat, for diversification. But we weren’t able to bring anything with us” when fleeing Myanmar, in order to have money to buy food in the market or to have goods to sell or barter for food.²⁹² Solema Khatun, around 55 to 60 years old, said similarly: “The biggest problem is that we are getting rice, oil, and lentils, but there is no fish or meat... Sometimes we want to eat fruits, but we don’t have any money... On the way from my home here, I saw they were selling palm [fruit] in the market. My heart wanted it, but I don’t have any money.”²⁹³

Everyone receiving the in-kind distribution gets the same, limited food items, but a lack of micronutrient diversity is linked to specific risks for older people, including “severe consequences for older people’s mental and physical health, their immune system, and their functional abilities.”²⁹⁴ In a context like Bangladesh, with an enormous camp population and limited infrastructure for moving goods to the camp area, the in-kind food distribution is likely to consist of staple foods only for the foreseeable future. There are, however, other ways to improve micronutrient diversity, preventatively and in treating those already malnourished.

²⁸⁶ ICESCR, Articles 11.1 and 11.2.

²⁸⁷ CESCR, General Comment 12, The right to adequate food (Art. 11), 12 May 1999, UN Doc. E/C.12/1999/5. The CESCR states further that “dietary needs implies that the diet as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages throughout the life cycle and according to gender and occupation. Measures may therefore need to be taken to maintain, adapt or strengthen dietary diversity and appropriate consumption and feeding patterns... while ensuring that changes in availability and access to food supply as a minimum do not negatively affect dietary composition and intake.” CESCR, General Comment 12, The right to adequate food (Art. 11), para. 9.

²⁸⁸ See, for example, CESCR, General Comment 6, The Economic, Social and Cultural Rights of Older Persons, 8 December 1995, UN Doc. E/1996/22, paras 5, 32; CESCR, General Comment 15: The right to water (Arts. 11 and 12 of the Covenant), 20 January 2003, UN Doc. E/C.12/2002/11, paras 2-6; Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted 18 December 1979, entry into force 3 September 1981, Article 14(2)(h); and UN General Assembly, Resolution 64/292: The human right to water and sanitation, 28 July 2010, UN Doc. A/RES/64/292.

²⁸⁹ CESCR, General Comment 15: The right to water (Arts. 11 and 12 of the Covenant), paras. 2, 12.

²⁹⁰ CESCR, General Comment 15: The right to water (Arts. 11 and 12 of the Covenant), para. 12.

²⁹¹ CESCR, General Comment 15: The right to water (Arts. 11 and 12 of the Covenant), para. 16(h).

²⁹² Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 14 February 2019.

²⁹³ Amnesty International focus group discussion with four older women refugees, Camp #18, Bangladesh, 23 February 2019.

²⁹⁴ For more on nutritional needs, see HelpAge International, *Nutrition interventions for older people in emergencies*, pp. 39-42, 52-53.

One way is to provide a cash transfer or e-voucher in lieu of or in supplement to in-kind food distribution, giving refugees some ability to buy a greater diversity of foods from local markets. Such a process is beginning to be implemented in the camps. The World Food Programme (WFP) has been transitioning households to an e-voucher system; about 50 percent of the refugee population received food assistance that way as of May 2019.²⁹⁵ People from families who had been transitioned to the e-voucher said the card included around 750 taka (US\$9) per person per month that can be used to buy some items of their choice; most people described using it at camp markets to purchase spices, chilies, onions, and dried fish.²⁹⁶

Many of the older women and men interviewed by Amnesty International had not been part of the transition to an e-voucher system as of late February 2019. They had heard rumours about the process, or received basic information from their *majhi*, or camp block leader,²⁹⁷ but many were confused about how it would operate in practice. A senior humanitarian worker in Bangladesh told Amnesty International that she was concerned some older people would be left off the household counts for the e-voucher system because they often send neighbours or other non-family members to pick up their distribution, and therefore might miss the registration.²⁹⁸ Another humanitarian worker expressed concern about whether the e-voucher system would be adequately explained, particularly to older people living alone or as the head of a camp household.²⁹⁹ Problems of communication are discussed in more detail in a section below, on page 54.

Even once the e-voucher system is fully implemented—and even if all older people are registered and understand the system—it is unlikely to adequately address older people’s specific needs related to diet diversity and micronutrients. It also seems likely to put many older people, especially those with limited mobility or who are shelter-bound, in a position of dependency on family members or neighbours who will be tasked with travelling to the approved e-voucher outlets to purchase food. There is a risk of exploitation. Volunteer networks to help older people with limited mobility get to e-voucher outlets and carry purchased items back to their shelter will be key. So will shelter-to-shelter protection monitoring.

One possibility would be to provide an additional cash supplement to households with older people. As described in Chapter 4, this is common practice in the IDP camps in Kachin State, where people with particular nutritional needs, including pregnant women and people age 60 or over, have been, for example, given 15,000 kyats (US\$10) per month compared to 11,000 kyats (US\$7) per month for the rest of the camp population. As discussed above in section 3.2, many older Rohingya women and men in the Bangladesh camps are spending a considerable amount of money on medication; an additional cash supplement would help mitigate those expenditures and better allow older people to purchase food that would enrich their diet and improve their physical and mental health.

Another way to improve micronutrient diversity among older women and men in the camps would be to distribute oral supplements, such as Vitamin A and iron tablets or powders.³⁰⁰ This appears to be happening on only a very small scale to date. Amnesty International interviewed older women and men from 15 different camps, and there was only one area—around Block D of Camp #1 East—in which older people reported having received a vitamin packet, as part of a one-off distribution in early 2019.³⁰¹

DIFFICULTY COLLECTING FOOD DISTRIBUTION, WATER

Collecting food assistance typically requires walking hundreds of metres, and at times more, to a food distribution site; queuing for several hours; and carrying a 30-kilogram sack of rice or other goods back to a shelter. Almost every older person described the process as not viable for her or him.

The humanitarian response has improved access to distributions. It has established “*special lines... to fast-track distributions to Extremely Vulnerable Individuals (EVIs)*”.³⁰² It has installed “*shaded areas, benches, latrines, and child play spaces to mitigate*” challenges associated with long waits.³⁰³ And it has organized

²⁹⁵ For more, see WFP Bangladesh, *Rohingya Refugee Response Situation Report #26*, 20 May 2019.

²⁹⁶ Amnesty International interviews, Bangladesh, February 2019. While beyond the scope of this report, several people voiced concerns that, with the food card, refugees can only buy from certain stores, which they said are inflating prices. There are reportedly 18 food items that people can buy with the card. See WFP Bangladesh, *Rohingya Refugee Response Situation Report #17*, 13 August 2018.

²⁹⁷ The *majhis* are refugees appointed to lead an area, usually a camp block. Almost always men, their role includes “*the organisation of distribution efforts... channelling communication to the refugee community... [and] handling small disputes.*” Humanitarian organizations also often rely on them as “*key informants for assessments and for project planning*”. ACAPS, *Rohingya Crisis: Governance and community participation*, June 2018, pp. 3, <https://www.acaps.org/special-report/rohingya-crisis-governance-and-community-participation>

²⁹⁸ Amnesty International telephone interview, March 2019.

²⁹⁹ Amnesty International interview, Cox’s Bazar, Bangladesh, February 2019.

³⁰⁰ HelpAge International, *Nutrition interventions for older people in emergencies*, pp. 39-42.

³⁰¹ Amnesty International interviews, Bangladesh, February 2019.

³⁰² Strategic Executive Group, *Joint Response Plan for Rohingya Humanitarian Crisis: March-December 2018 Final Report*, p. 24.

³⁰³ UNHCR written response, 31 May 2019, p. 9.

porters to assist people considered “vulnerable” in carrying items to a shelter.³⁰⁴ But each of those actions, while important, assume a person is able to reach the distribution site in the first place, as UNHCR recognizes. For those unable to get to a distribution site, UNHCR says “access and service delivery remains an ongoing issue,” referencing only a system of “informal community-led volunteers” to provide help.³⁰⁵

Outside of the six camps where HelpAge operates, all of the older women and men interviewed by Amnesty International said they had to rely on family members or neighbours to collect their food distribution, whether or not those people were on the same distribution card. As with other issues, the current set-up forces most older people to be dependent on the help of family members or neighbours. It means that older people who are living alone or with family members with disabilities often face greater difficulties. For example, Sokhina Khatun, around 90 years old, lives alone in her shelter in Camp #1 East; her only child who lives nearby is a daughter with a physical disability resulting from a serious leg injury she suffered while fleeing Myanmar.³⁰⁶ Sokhina Khatun said that, to collect her food distribution, she pays either a grandchild or a neighbour 20 taka (US\$0.25) once or twice a month.³⁰⁷ Without any way to generate income, even small expenditures force older refugees into foregoing other necessities, like a more diverse diet or medical care.

Despite the challenges, most older refugees said they managed with the food distribution, as it only required either they or someone on their behalf collect it once or twice a month. Many described greater difficulties with collecting adequate water, as they have to make daily trips; some women described needing to collect water 10 or more times a day and often finding pumps broken or tanks empty.³⁰⁸ A woman in her late 50s in Camp #24, who still sometimes collects her own food distribution, though “heavy” and “a long way away,” said there was nowhere near her shelter to get water.³⁰⁹ She said that even when she went to the closest water point, which was far from her shelter, there was often no water in it—forcing her to go further.³¹⁰

As with latrines, the challenge usually isn’t the distance as much as the terrain between a shelter and a water point. A 60-year-old woman in Camp #15 told Amnesty International that water is particularly difficult for her to collect, as the closest pump is at the bottom of the hill on which her shelter is located. “It’s difficult, I feel unsafe,” she said. “I need to go up the hill [after the collecting water]. I’m afraid I may fall down.”³¹¹

Ata Ullah, 60, in Camp #13, described the same problem in reverse: “There is a water point at the top [of the hill]. We can’t use it. When we go up [the hill]... I have a lot of problems breathing, it’s very steep.”³¹²

Khalunisa, a 60-year-old Rohingya woman assisting BRAC with implementing a Women Friendly Space in Camp #1, said that women, including older women, are primarily tasked with collecting water in the camps.³¹³ The challenge of accessing water points, which she said is made more difficult by the number of water points that are often not working, therefore falls disproportionately on them.³¹⁴

INADEQUATE COMMUNICATION ABOUT CHANGES, RESOLVING PROBLEMS

Several older people said that members of their camp household—at times including themselves—had been left off of the food ration card, which put them in an even more tenuous situation in terms of having access to adequate food. At root, the problem is that, to better respect the rights of older people, communication about humanitarian assistance and resolution mechanisms needs to become more effective and inclusive.

Kamalun Nisa, around 75 years old, told Amnesty International that her camp household includes eight people, but that only six are on the food ration card. She said:

“On the day of the registration [to update the list], I couldn’t go because I was sick. I was about to die, I was so sick, [and] the registration centre is a little far from us... My daughter was giving birth [so she couldn’t go either]. So they didn’t count me or my daughter...”

³⁰⁴ IOM written response, 30 May 2019, p. 4 (“IOM doesn’t provide food services, but the concern applies to service provision such as shelter/NFI or LPG; in these locations vulnerable individuals are ‘fast tracked’ for distribution, so they are served first before IOM porters take the relief items to their shelter location across the camps”); UNHCR written response, 31 May 2019, p. 9.

³⁰⁵ UNHCR written response, 31 May 2019, p. 9.

³⁰⁶ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 14 February 2019.

³⁰⁷ Amnesty International interview, Camp #1 East (Kutupalong Camp), Bangladesh, 14 February 2019.

³⁰⁸ Amnesty International interviews, Bangladesh, February 2019. See also Reuters, “Life in the Camps”.

³⁰⁹ Amnesty International interview, Camp #24 (Leda Camp), Bangladesh, 17 February 2019.

³¹⁰ Amnesty International interview, Camp #24 (Leda Camp), Bangladesh, 17 February 2019.

³¹¹ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

³¹² Amnesty International interview, Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

³¹³ Amnesty International interview, Women’s Friendly Space in Camp #1 (Kutupalong Camp), Bangladesh, 20 February 2019.

³¹⁴ Amnesty International interview, Women’s Friendly Space in Camp #1 (Kutupalong Camp), Bangladesh, 20 February 2019.

*We'd heard they would come around to register us, but until now, they've never come... It's been about three months that we've only received food for six people [even though we're a house of eight]. We've suffered a lot. We've had less food, but what can we do? We just had to manage.*³¹⁵

Kamalun Nisa said their *majhi* had told them he would put in a request to change their food ration to being for eight people, but that it still was not resolved as of late February 2019.³¹⁶

A 63-year-old woman in Camp #24 said similarly that in her family of six, two people were not on the ration card because they had come to Bangladesh much later and had not been registered.³¹⁷

A senior humanitarian worker in Cox's Bazar said that being left off the distribution list should, in theory, have an easy and quick fix. But, she said, *"a major problem is people's lack of knowledge about what services are available—who to talk to when you have a problem isn't well known."*³¹⁸

Related, older people in several camps expressed frustration about recent delays or reductions in their food distribution—without knowing why there were problems or for how long they would continue. For example, an 85-year-old woman with a physical disability that left her unable to walk told Amnesty International that, in her area of Camp #11, her family had always received two distributions per month, but that it had been almost a month since their last distribution.³¹⁹ The woman said her son had gone on their behalf, as always, to collect the distribution, but that he had been told it was not their turn. She said they complained to the *majhi*, *"but he has no power. He says he will come, but he doesn't come... We have to eat less now."*³²⁰

Johara Begum, 65, said that there were nine people on her family's ration card in Camp #1 West. She said they had never had problems with the food distribution until a month earlier when, after long receiving two sacks of rice for their household, they were given one sack without explanation as to the change. *"For nine people, it's not enough,"* she said. *"We can't ask [about problems like this]. The majhi has to ask for us. The majhi said if we're not given it, how can he distribute more?"*³²¹ Several other older refugees in Camp #1 West described similar problems of delayed or reduced distributions in early 2019, without explanation.³²²

Finally, Soyed Alom, 60, said his food ration card had worked fine for seven months, but that, in early 2019 it had been rejected twice *"because of the fingerprint"*.³²³ At the food distribution centre, he was told to inform IOM; he said he did, and was told the problem would be resolved, but when he tried again to collect the food distribution—three days in a row—he was rejected. He said no one had taken a new fingerprint. When interviewed on 14 February 2019, Soyed Alom had missed two food distributions in a row, as well as the distribution of a replacement gas cylinder.³²⁴ He said that, in order to eat, his family was relying on the assistance of neighbours, and that about five percent of families in his block faced similar challenges.³²⁵

While the specific issues vary, the underlying problems are similar: inadequate outreach and communication about changes in assistance and how to resolve problems. The lack of adequate outreach with the Rohingya refugee population affects almost everyone in the camps, but has a disparate impact on older people and people with disabilities. The UN agencies leading the response recognized this in the Joint Response Plan review of 2018, reporting that *"under-resourced services impact outreach to persons at heightened risk, especially persons with disabilities [and] elderly persons without support,"* among other identified groups.³²⁶

In response to a question about standard practice for disseminating information to refugees, IOM said that camp officials are informed in coordination meetings and that information is shared through various community representation mechanisms, including *mahjis*, community volunteers, elder councils, and imams. IOM also said there is more direct dissemination, including through town hall meetings, information desks, and placing visuals at key locations like distribution sites.³²⁷ Those means are all less likely to reach older people, especially older people with limited mobility or who are living alone. IOM and UNHCR both indicated further that there is shelter-to-shelter outreach,³²⁸ though this does not appear to

³¹⁵ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

³¹⁶ Amnesty International interview, Camp #15 (Jamtoli Camp), Bangladesh, 15 February 2019.

³¹⁷ Amnesty International interview, Camp #24 (Leda Camp), Bangladesh, 17 February 2019.

³¹⁸ Amnesty International interview, Cox's Bazar, Bangladesh, 22 February 2019.

³¹⁹ Amnesty International interview, Camp #11 (Balukhali 2 Camp), Bangladesh, 16 February 2019. On 16 February 2019, an Amnesty International delegate photographed her food ration card, which indicated she last received a distribution on 22 January—after she previously, as described, had received a distribution every two weeks. Photograph on file with Amnesty International.

³²⁰ Amnesty International interview, Camp #11 (Balukhali 2 Camp), Bangladesh, 16 February 2019.

³²¹ Amnesty International interview, Camp #1 West (Kutupalong Camp), Bangladesh, 17 February 2019.

³²² Amnesty International interviews, Camp #1 West (Kutupalong Camp), Bangladesh, 17 and 19 February 2019.

³²³ Amnesty International interview, Balukhali 2 Camp, Bangladesh, 14 February 2019.

³²⁴ Amnesty International interview, Balukhali 2 Camp, Bangladesh, 14 February 2019.

³²⁵ Amnesty International interview, Balukhali 2 Camp, Bangladesh, 14 February 2019.

³²⁶ Strategic Executive Group, *Joint Response Plan for Rohingya Humanitarian Crisis: March–December 2018 Final Report*, pp. 40–41.

³²⁷ IOM written response, 30 May 2019, p. 3.

³²⁸ IOM written response, 30 May 2019, p. 3; and UNHCR written response, 31 May 2019, pp. 4–5.

be working adequately in practice, at least for most of the older people interviewed by Amnesty International.

IOM's response recognized critical shortcomings, saying that *"better integration of members/representatives" of older people and people with disabilities "to existing and/or planned community representation structures will be key to ensure a meaningful and consistent consultation"* and that *"one way of improving should also be a stronger effort in producing more specific communication materials and services."*³²⁹ IOM also noted, *"A lot of attention [has] been put on engaging youth groups but very limited resources have so far reduced opportunities to redirect similar efforts to elderly individuals."*³³⁰

UNHCR's response highlighted a number of important initiatives that are being developed, improved, or expanded, the full extent of which are included in Annex I. It noted that Community Outreach Members (COM) have been doing shelter-to-shelter outreach, including for people with disabilities and older people who are shelter-bound, and that there has been *"improved disaggregated data tracking since March 2019"* of such efforts, which show *"731 refugees aged 60+ have received home visits, participated in awareness sessions, or were referred for assistance/additional support."*³³¹ UNHCR also said its *"Child Protection programme is expanding its intervention through establishment of 29 Caregivers Groups and 13 Committees composed of elderly caregivers... Children attending CFS and 300 elderly people will benefit from intergenerational exchanges and positive transfer of experience and knowledge."*³³²

Donors should better fund such efforts, and the humanitarian response more generally. But even with inadequate funding support, humanitarian actors—and, as leaders of the response, UNHCR and IOM in particular—must ensure that greater efforts are made to communicate inclusively and to consult meaningfully with older people. Although progress has been made, many older refugees remain left behind.

ACCESS TO SAFE COOKING FACILITIES

Many older refugees said the difficulty of obtaining adequate food and nutrition was exacerbated by the need to collect or buy firewood or other cooking material. The problem of accessing safe cooking facilities is not limited to older refugees, but, as with other issues, appears to affect them disproportionately. The rights to an adequate standard of living and to housing include access to safe cooking facilities.³³³

In late 2018, the humanitarian response started distributing cooking fuel, in an effort to replace firewood; during the period of research for this report, there was incremental progress, though some camps were yet to begin receiving cooking fuel.³³⁴ Where cooking fuel was not being distributed or was insufficient, people described having to choose among travelling long distances to collect firewood, which left them in conflict with host communities; trying to collect leaves or other low-quality cooking material around camp; or, at times, being unable to cook. Ata Ullah, a 60-year-old man living in Camp #13, told Amnesty International:

*"Another difficulty we have is cooking [material]. I'm an older person, and to go to collect firewood is very hard. We need to walk five or six miles [roundtrip] to collect firewood; I can't do it, I don't have the strength. We just collect branches from here and there, and papers from the market, and we use those to cook. If we can't manage [to get enough cooking materials], we can't cook."*³³⁵

Eight older women in Camp #13 likewise said the lack of a gas cooker, and the related need to collect firewood or other cooking material, was, as of late February 2019, their biggest problem in the camps.³³⁶ Several older women said, like Ata Ullah, they had to travel further and further to find firewood, as the trees close to the camp had been cut down. The further they go, the closer they get to Bangladeshi villages, which has led to rising tensions between refugees and host communities. *"Collecting firewood has become the biggest challenge,"* said Mahamuda, around 55 years old. *"It used to be close [that we could get firewood], but now we have to go far. And sometimes, the forest people chase us and beat us."*³³⁷ Mahamuda said she sometimes collects leaves in the camp for cooking fuel, while other times she has to buy firewood, stretching

³²⁹ IOM written response, 30 May 2019, p. 3.

³³⁰ IOM written response, 30 May 2019, p. 3.

³³¹ UNHCR written response, 31 May 2019, p. 5.

³³² UNHCR written response, 31 May 2019, pp. 5-6.

³³³ ICESCR, Article 11 (adequate standard of living); CESCR, General Comment 4: The Right to Adequate Housing (Art. 11 (1) of the Covenant), 13 December 1991, (including, as part of the right to housing, *"sustainable access to... energy for cooking"*).

³³⁴ Strategic Executive Group, *Joint Response Plan for Rohingya Humanitarian Crisis: March-December 2018 Final Report*, pp. 15, 19, 24.

³³⁵ Amnesty International interview, Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

³³⁶ Amnesty International interviews, Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

³³⁷ Amnesty International interview, Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019. Fokir Mohammed, 60, said that due to conflict with the host community, people in his camp—Camp #25—had been forbidden from gathering firewood. Amnesty International interview, Camp #24 (Leda Camp), Bangladesh, 17 February 2019. Fokir Mohammed lived in Camp #25 but was interviewed in Camp #24.

her financial resources and limiting her ability to supplement what is provided in the food distribution.³³⁸

As with other issues, the situation is particularly difficult for older persons living alone. *“I’m suffering a lot as a single person,”* said Mayma Khatun, around 55 to 60 years old. *“Sometimes I starve because I can’t cook, I have no firewood. If I go to the forest, the villagers sometimes beat us, they don’t like us to go there.”*³³⁹

In addition to tensions with host communities, a 55-year-old woman in Camp #13 linked the problem of cooking material to gender-based violence, telling Amnesty International, *“The biggest challenge I face is firewood. If I insist too much to my husband [that we need firewood], sometimes he beats me.”*³⁴⁰

By February 2019, when Amnesty International last undertook research in Cox’s Bazar for this report, refugees in certain camps had received gas cookers, improving their access to adequate food; however, other camps, including those identified in this section, remained without. Some refugees who receive gas or kerosene distributions supplement it with firewood if they run out.

Several senior humanitarian workers interviewed by Amnesty International said the distribution of gas cookers was a time-consuming process. They said that it was a major logistical undertaking, to distribute tens of thousands of cookers and gas cylinders—which then need to be replenished. More significantly, in terms of the delay, they said each household had to be trained on how to use the gas cookers—to mitigate the risk that a fire would be started, which could be devastating given the density of camp structures.³⁴¹

In future humanitarian crises, donors and humanitarian actors should prioritize funding and undertaking the distribution of cooking material as quickly as possible. Where, as in Cox’s Bazar, the distribution of cooking material will be time-consuming, resulting in lengthy delays for later groups of recipients, humanitarian actors should identify initial recipients using a human rights compliant approach that takes into consideration people’s specific needs and challenges. An inclusive approach, that gives priority to those who, as a result of older age, disability, or other factors, may not be able to find alternative sources of cooking material as easily, would better ensure that everyone’s right to food is realized.

Even in camps where gas cookers have been distributed, some older refugees—and again, particularly those who live alone—struggle to have their right to food met. Shair Banu, around 90 years old, said that when the gas cylinder distribution occurred in her area of Camp #17, she was told that, since she lived alone, she would need to share with a family in the neighbouring shelter. She said the family was sometimes accommodating, but other times *“we have a quarrel when I want to use it,”* and the family does not let her—or lets her only on their terms.³⁴² The way the gas cookers were distributed had put Shair Banu in a situation of dependency on her neighbours and meant she is sometimes unable to cook or eat.³⁴³

³³⁸ Amnesty International interview, Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

³³⁹ Amnesty International interview, Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

³⁴⁰ Amnesty International interview, Camp #13 (Thaingkhali Camp), Bangladesh, 20 February 2019.

³⁴¹ Amnesty International interviews, February 2019.

³⁴² Amnesty International interview, Camp #17, Bangladesh, 24 February 2019.

³⁴³ Amnesty International interview, Camp #17, Bangladesh, 24 February 2019.

ZATAN HKAWNG NYOI, ETHNIC KACHIN, 67 YEARS OLD³⁴⁴

FROM SUT YAR YANG VILLAGE, WAINGMAW TOWNSHIP, KACHIN STATE

DISPLACED SINCE 2011, CURRENTLY LIVING IN QUARTER #2 LHAOVO BAPTIST CHURCH IDP CAMP



Zatan Hkawng Nyo, 67, sits in her shelter in Quarter #2 Lhaovo Baptist Church Camp, Myanmar, 11 December 2018. © Hkun Lat / Amnesty International

“I’ve lived [in the camp] since the beginning of this conflict—since 2011. Fighting occurred in my village; I fled here the third time it happened... Our village is between a KIA post and a Myanmar Army post. We could see the Myanmar Army post. We were so terrified of the soldiers...

I fled with three of my neighbours. My son was studying in Myitkyina, so I was alone with these three other households... I was terrified. Now, whenever I hear a loud bang, I’m scared. Even a small bang scares me.

On the road we saw bombs like this size around [about 8-10 centimetres], with a length from [my elbow to my hand]. One person died because of a landmine [while fleeing], and another one was injured. The person who died, died instantly. The person who got injured is blind.

I fled to Shwe Nyaung Pin on foot, because no tricycle drivers were there to take us because of the fighting... It took us more than an hour [to walk from Sut Yar Yang to Shwe Nyaung Pin]. From Shwe Nyaung Pin, we came by tricycle [to Waingmaw town]. I couldn’t bring any of my belongings—any blankets, or rice, or any [kitchenware] we used at home. Now I use blankets that were delivered [by humanitarian organizations]. When I arrived here, we had nothing.

We didn’t sleep on the way here. The Myanmar soldiers checked our NRCs. I brought my late husband’s NRC too. When they saw it, they said he was in the KIA. They threatened me, said they would take me away. I told them my husband was already buried, and they asked if that was true... They were bragging, saying we were the wives of KIA soldiers, who knows what they would do to us... Then they let me go.

No one is left in Sut Yar Yang village, no one at all. The Myanmar Army burned down most of the houses.

I’ve fled so many times in my life. It was around 1966 or 1967, [the first time I fled]. I was in a village in Chipwi Township. I was 13 or 14 years old at the time... [My village] was near the Myanmar Army Battalion 58. The KIA came and surrounded the battalion, and the fighting happened...

We fled to the jungle all the time [when I was young]... It was at least two to three times a year from 1966 to 1968. I fled with my parents—we fled to the jungle, where neither the Myanmar Army nor the KIA could

³⁴⁴ Amnesty International interview, Quarter #2 Lhaovo Baptist Church IDP Camp, Waingmaw Township, Myanmar, 11 December 2018.

reach. We fled sometimes for three nights, for four nights, sometimes for weeks at a time. When we thought the Myanmar Army had moved away, we went back to the village.

We carried chickens with us, then we got scared that if the chickens made a sound the Myanmar Army would hear and find us, so we killed the chickens and ate them... There were people who looked out for the Myanmar soldiers [coming to where we were hiding]... I remember hearing the sound of bullets—when the bullet hits the bamboo, it makes a sound. *Thwack*.

In 1969, I moved to Sut Yar Yang... because of the fighting in my village [in Chipwi Township].

I don't even know how to express my experiences. I don't know what will happen in the future. I've had to run my whole life, and now I've had to run again. I've never been able to build up [my life].

It's been almost eight years that we've been here [in the camp]. I have financial difficulties because no one wants us older people to work as cash labourers. We don't have anywhere to make money. I only receive 15,000 kyats (US\$10) per month [in humanitarian assistance].

If possible, I would like to work in shifting cultivation—[cultivating] sweet potato, ginger. That's the only thing I know how to do. I've been doing it my whole life...

I've tried, I've approached the employers and said I want to work. They said I'm too old, that I won't be able to walk that far [to the fields] to work. I feel so sad because I need money and I want to work, but there is no opportunity for me. I feel so depressed.

I just borrow money from people when possible. I tell them that they will be old like me some day.

My hand shakes from time to time, and I have a heart condition... There's basic medical care in the camp, but the only thing they can provide is energy supplement pills and oral medication. They can't give us the shots we need. And they only provide oral medications when they come [several times a month].

If there is peace, if possible, I would go back [to my village]. I want to because I could do shifting cultivation farming there... It's scary to go back to the jungle—to rural areas—because of the Myanmar Army.

We IDPs, we didn't have any opportunities in our life. Our lives are not developed... A life as an IDP is not one of pride. It's a shameful situation. But there's nothing we can do to change it."

4. HUMANITARIAN RESPONSE IN MYANMAR

“Older people here are still strong. Physically, they are fit, but the impact of displacement is something else—being far away from their farm.”

Senior representative of an international humanitarian organization in Kachin State, Myanmar.³⁴⁵

“It’s not about food. People aren’t living with dignity. And the older you are, the worse it is.”

Senior representative of a UN agency, speaking about the situation of displaced people in northern Myanmar.³⁴⁶

In northern Myanmar, more than 105,000 people from ethnic minorities live in internally displaced person (IDP) camps, many of which have existed for close to a decade; depending on where the fighting is most intense in a given week or month, thousands more people at times live in makeshift camp-like sites while displaced for shorter periods. In Rakhine State, the ongoing fighting between the Myanmar military and the Arakan Army has displaced at least 30,000 more people since late 2018; their temporary displacement threatens to turn into a long-term situation if fighting continues to intensify.³⁴⁷

During shorter-term displacements, older women and men often face disruptions in their access to essential medication and to their normal source of livelihood, which then has secondary effects on their rights to food and physical and mental health. During longer-term displacement, older women and men describe discrimination in accessing work and even some humanitarian programs, particularly those aimed at livelihood training and support. They also tend to be excluded, or at least underrepresented, among camp leadership positions, denying older people—especially older women—a voice and role in decision-making.

The Myanmar authorities are responsible for respecting, protecting, and fulfilling the rights of displaced older people; far from doing so, the authorities’ restrictions on humanitarian access have directly undermined rights to food, water, shelter, and physical and mental health. Some government-run or government-approved programs in the camps also discriminate against older people and people with disabilities, in breach of Myanmar’s obligations as a state party to the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of Persons with Disabilities.

For their part, donors and humanitarian organizations assisting displaced people in Myanmar need to better ensure that all programs, including livelihood assistance programs, are inclusive and do not discriminate

³⁴⁵ Amnesty International interview, location withheld to protect anonymity, Myanmar, December 2018.

³⁴⁶ Amnesty International interview, location withheld to protect anonymity, Myanmar, December 2018.

against older people and people with disabilities. The humanitarian community should also better respond to older people's specific rights and needs, including in the provision of health services and in communicating changes to assistance programs.

This report does not examine the situation of older people confined to IDP camps in Rakhine State, where an estimated 128,000 people, overwhelmingly ethnic Rohingya, have been displaced since 2012. Amnesty International has not had access to those camps during the relevant research period. It is likely, however, that many of the issues described in this report exist for older people in those camps, and indeed may be exacerbated both by the lack of humanitarian access and the severe movement restrictions the authorities have imposed, which make the displaced community almost entirely dependent on aid for their survival.³⁴⁸

SEVERE RESTRICTIONS ON HUMANITARIAN ACCESS

Across Myanmar, military operations are usually accompanied by severe restrictions on humanitarian access. Amnesty International has documented how such restrictions have been part of the crimes against humanity committed against the Rohingya population in northern Rakhine State, including through tactics that starved families into fleeing to Bangladesh,³⁴⁹ and amount to serious human rights violations, and potentially war crimes, during the ongoing military operations against the Arakan Army in Rakhine State and against ethnic armed groups in Kachin and northern Shan States.³⁵⁰

This report will not examine the issue of humanitarian access in detail, given Amnesty International's prior documentation. Severe access restrictions continue in Kachin and Rakhine States, with lesser, though still harmful, restrictions in northern Shan State. In May 2019, the UN Office for the Coordination of Humanitarian Affairs (OCHA) reported that humanitarian actors had "effective access" to only 44 percent of displaced people in northern Myanmar, defining "effective access" as "areas where travel authorizations for both national and international humanitarian actors are regularly approved."³⁵¹ Of the 38 travel authorization requests the humanitarian community submitted for northern Myanmar in March 2019, only one was approved without restriction, 12 were approved with restrictions, and 25 were not approved; OCHA reported that water points and latrines were deteriorating, that "over 7,500 families need new or renovated shelters" and that restricted access in February 2019 had "prevented humanitarian agencies from delivering much needed warm winter clothing to children and other vulnerable people."³⁵²

Access to non-government-controlled areas (NGCA) is particularly restricted, to the point of being blocked for UN agencies and most international humanitarian organizations. Local civil society organizations operating in NGCA risk arrest and prosecution by the Myanmar authorities.³⁵³ Amnesty International did not have access to NGCA, including KIO-controlled areas of Kachin State, during this research, so this chapter focuses on the situation of older people displaced to IDP camps and temporary IDP sites in government-controlled areas. As Amnesty International reported in June 2017, and as Fortify Rights and Refugees International have documented more recently, the Myanmar authorities' restrictions to NGCA undermine both the delivery of essential assistance and the monitoring of displaced people's needs.³⁵⁴

Food and non-food items often have to be brought to NGCA from or through China, which Chinese authorities block intermittently. When Amnesty International delegates were in Kachin State in December 2018, for example, the Chinese military had for several weeks been running military exercises near the border with Myanmar and had blocked humanitarian organizations from moving rice and other goods across the border to NGCA during that period—leading to severe rice shortages in the NGCA camps, according to several senior humanitarian workers.³⁵⁵ The impact of food and medicine shortages is likely to have a disproportionate impact on older people, many of who have specific medical and nutritional needs and are less likely to be able to pursue paid work to fill assistance gaps, either due to discriminatory

³⁴⁷ OCHA, Myanmar: New Displacement in Rakhine and Chin States (as of 07 May 2019), 13 May 2019,

https://reliefweb.int/sites/reliefweb.int/files/resources/MMR_Rakhine_New_Displacement_07_May_2019.pdf

³⁴⁸ While referred to as IDP camps, they are part of the authorities' apartheid regime and operate more like ethnic detention centres. For more on the camps in central Rakhine State and the movement restrictions, see Amnesty International, "Caged without a Roof".

³⁴⁹ Amnesty International, "We Will Destroy Everything", pp. 101-111.

³⁵⁰ Amnesty International, "No One Can Protect Us", pp. 31-33; Amnesty International, "All the Civilians Suffer", pp. 34-36.

³⁵¹ OCHA, Myanmar: Humanitarian access in Kachin and northern Shan (as of March 2019), 7 May 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/MMR_Kachin_northernShan_Humanitarian_Access_Mar_2019.pdf

³⁵² OCHA, Myanmar: Humanitarian access in Kachin and northern Shan (as of March 2019), 7 May 2019.

³⁵³ Amnesty International interviews, Myitkyina, Kachin State, Myanmar, December 2018. See also Lawi Weng, "Main Kachin Aid Group Ordered to Halt Humanitarian Work in Rebel-Held Areas," *The Irrawaddy*, 14 June 2018, <https://www.irrawaddy.com/news/main-kachin-aid-group-ordered-halt-humanitarian-work-rebel-held-areas.html>

³⁵⁴ Amnesty International, "All the Civilians Suffer", pp. 34-36; Fortify Rights, "They Block Everything": Avoidable Deprivations in Humanitarian Aid to Ethnic Civilians Displaced by War in Kachin State, Myanmar, August 2018; and Refugees International, *Suffering in Shadows: Aid Restrictions and Reductions Endanger Displaced Persons in Northern Myanmar*, December 2017.

³⁵⁵ Amnesty International interviews, Myanmar, December 2018.

attitudes (see section 4.2, below) or reduced mobility. Humanitarian organizations' inability to transport new shelter materials into NGCA is also likely to have a disproportionate impact on older people. Some camps in NGCA are in mountainous areas where temperatures drop near or below freezing during winter; dilapidated shelters put many older people at risk of disease and other ailments.³⁵⁶

The Myanmar authorities' restrictions on humanitarian access violate the rights of displaced people, including older women and men, to food, water, housing, and health.³⁵⁷ They also make for a challenging environment for the humanitarian community, including related to the problems described in this Chapter.

4.1 ACUTE, SHORT-TERM DISPLACEMENT

In northern Shan State, more than 11,000 people were displaced by conflict between January and March 2019,³⁵⁸ part of the more than 45,000 people displaced across northern Myanmar since January 2018.³⁵⁹ In contrast to the refugee situation in Bangladesh and to the long-term displaced population in Kachin State (see section 4.2, below), many of those in northern Shan State do not end up in established camps. Rather, they tend to stay for around a week to a month in a monastery or other makeshift displacement site, then return to their village when fighting moves to another area. Many end up being displaced again and again, an acute form of short-term displacement that has a specific impact on older people, particularly in disrupting health care and livelihoods. A similar dynamic may be emerging in Rakhine State, during the ongoing conflict between the Myanmar military and the AA.

Amnesty International's findings here are preliminary, as delegates have undertaken fewer interviews with older women and men living through acute, short-term displacement than with older people living in established camps in Bangladesh and in northern Myanmar. People, including older people, living through acute displacement are hard to access, due to the Myanmar authorities' travel restrictions in conflict areas. The villages from which people were fleeing in northern Shan State and in Rakhine State were not accessible to Amnesty International; even most towns to which people had been displaced were in areas where foreigners are forbidden to go without written authorization from local and union-level officials.

DISRUPTIONS TO HEALTH CARE, LIVELIHOODS

Several older people displaced to a makeshift site were running out of medication to treat chronic diseases. Government and humanitarian medical teams who visited the sites had not addressed the situation.

Sam Kam, a 77-year-old ethnic Shan woman from a village in Namtu Township, northern Shan State, told Amnesty International in March 2019 that, as a result of fighting between ethnic armed groups in and around her village, she had fled her home three times since August 2018, in addition to a prior displacement in December 2016. Tired of suffering from motion sickness each time she fled by shared vehicle, she once stayed for a month with an adult son in Lashio, before returning to her village when the situation seemed calm.³⁶⁰ Sam Kam was displaced again in March 2019, this time to a monastery in Hsipaw town. She said that, for two to three years, she had taken blood pressure medication, buying tablets from a pharmacy in her village. When interviewed by Amnesty International, she said she had only one or two tablets left. A nurse had come once to the monastery where Sam Kam was staying and provided a few tablets, but Sam Kam didn't know if anyone would come again. She was unsure how she would otherwise get a refill on the medication she needed; she hoped a daughter might be able to help take her and pay for the medication.³⁶¹

Similarly, Pya Pa Mei, a 65-year-old Lisu woman from Lai Mak village, Hsipaw Township, Shan State, was staying in a makeshift site near Hsipaw town after having to flee fighting between ethnic armed groups as she started to cook breakfast several weeks earlier. She lives with diabetes, for which she was hospitalized in late 2018, and needs to take medication daily, which she said costs her 33,000 kyats (US\$21) for a 15-day

³⁵⁶ For related information and interviews, see Amnesty International, "All the Civilians Suffer", pp. 34-36.

³⁵⁷ ICESCR, arts. 11 and 12.

³⁵⁸ OCHA, Myanmar: New Displacement in Shan State (1 Jan to 9 Apr 2019), 22 April 2019. OCHA Myanmar reported on its Twitter account that, as of 9 April, all of the 11,000 people had returned home. OCHA Myanmar, 23 April 2019, <https://twitter.com/ochamyanmar/status/1120585006794051587> (last accessed 20 May 2019).

³⁵⁹ OCHA, Myanmar: Kachin and northern Shan Humanitarian Access Tracking (February 2019), 4 March 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/MMR_Kachin_Shan_Access_Tracking_Feb2019.pdf

³⁶⁰ Amnesty International interview, Hsipaw, Shan State, Myanmar, 26 March 2019.

³⁶¹ Amnesty International interview, Hsipaw, Shan State, Myanmar, 26 March 2019.

supply. While scraping together enough money was always a challenge, she said the conflict's disruption of the work she normally did to make money left her in an even more precarious situation:

"The medication is going to run out, but I don't have enough money to get [more]. The fighting has made it harder. Normally I can go to the farm or the forest to work to get some money—I can clear other people's farms, or collect corn that people have left and sell it. But now I can't, so there's no way for me to earn money... Right now I really need the medication."³⁶²

When interviewed, Pya Pa Mei said she had only two days left of her medication. She was the only person in her family in the displacement site; her husband and one of her three adult children work in a neighbouring country and were not even aware of her current situation. She had spoken with a nurse who visited the camp several days earlier, but had not seen the nurse since and did not know if any help would be provided.³⁶³

As Pya Pa Mei indicated, even short-term displacement can have a devastating economic impact. People's inability in rural areas to access farmland during critical times—including the land preparation period, the planting period, and the harvest period—has serious consequences on their rights to food and health, as examined in Amnesty International's May 2019 briefing on human rights violations during the conflict in Rakhine State.³⁶⁴ Older people face particular challenges when they lose out on a farming cycle, as they often do not have alternative sources of livelihood available, such as working on the farms of people in communities near their displacement site, in part due to discriminatory attitudes (see section 4.2, below).

The Myanmar security forces at times compound the situation by looting villages from which people have been displaced. A 67-year-old ethnic Rakhine man from a village in Ponnagyun Township, Rakhine State, whose detention and beating at the hands of Myanmar soldiers was described on page 20, was one of three witnesses Amnesty International interviewed to soldiers' mass looting and destruction of civilian property in his village.³⁶⁵ After fleeing to a makeshift displacement site for around 10 days, he returned to find his house ransacked; soldiers had destroyed or stolen his family's clothes, cooking pots, and solar panel. Soldiers had also taken the family's two most valuable possessions: gold necklaces that belonged to his two adult daughters. Most devastatingly, the man said, soldiers stole a large sack of uncooked rice; the only thing soldiers did not steal or destroy was the paddy rice he had not yet de-husked.³⁶⁶

"Since coming back to the village, I have a lot of difficulties," the 67-year-old man said. *"I have nothing right now... I was left with only some paddy. I unshelled it, and that's what [we're eating]. I have only one longyi... When the paddy is gone, my family will have a lot of hardship."³⁶⁷* The man said he has high-blood pressure, which requires him to take medication every day.³⁶⁸ The looting, and his family's lack of access to their farm as a result of the conflict and short-term displacement, put his health and access to food at greater risk.

LIMITED AND INACCESSIBLE INFRASTRUCTURE

People displaced temporarily tend to be housed in monastery compounds, on church grounds, or in open-air settings on donated land. Given their temporary nature, the sites—even those used repeatedly during waves of displacement—often have only basic infrastructure, which impacts older people in specific ways.

Sam Kam, 77, who was displaced in March 2019 to Manli monastery in Hsipaw town from her village in Namtu Township, told Amnesty International that it was difficult for her to go up and down the stairs to the second floor of the monastery where people slept. She said she could do it only once a day, so she typically received assistance to come down the stairs in the morning, and then spent the day outside where, she said, *"there are more people to talk to."*³⁶⁹ An 84-year-old ethnic Shan man displaced to the same monastery from a different village in Namtu Township described similar challenges in moving around the monastery, which one of his children said made it hard for the father to access the latrine.³⁷⁰

Makeshift displacement sites housed somewhere other than a monastery or church are often worse. Pa Mon, a 72-year-old ethnic Lisu corn farmer from Loi Mok village in Hsipaw Township, Shan State, said fighting between ethnic armed groups in her village in March 2019 forced her to flee to an open-air site in Nalwe village, outside Hsipaw town. Except for a few blankets and changes of clothes, she had to leave everything behind, including money. She found the general situation in the makeshift site difficult, due to the

³⁶² Amnesty International interview, Hsipaw, Shan State, Myanmar, 26 March 2019.

³⁶³ Amnesty International interview, Hsipaw, Shan State, Myanmar, 26 March 2019.

³⁶⁴ Amnesty International, *"No One Can Protect Us"*, pp. 31-33.

³⁶⁵ For more detail on this incident, see Amnesty International, *"No One Can Protect Us"*, pp. 24, 28.

³⁶⁶ Amnesty International interview, Sittwe, Rakhine State, Myanmar, 30 March 2019.

³⁶⁷ Amnesty International interview, Sittwe, Rakhine State, Myanmar, 30 March 2019.

³⁶⁸ Amnesty International interview, Sittwe, Rakhine State, Myanmar, 30 March 2019.

³⁶⁹ Amnesty International interview, Manli monastery, Hsipaw, Shan State, Myanmar, 26 March 2019.

³⁷⁰ Amnesty International interviews, Manli monastery, Hsipaw, Shan State, Myanmar, 26 March 2019.

noise and congestion, and said the lack of privacy for bathing was especially problematic for her, as an older woman. *“We shower and wash in the river—we all wash together,”* Pa Mon said. *“In the village, water comes by pipe to the house. Now [here] it’s not so private. We have to share the river.”*³⁷¹

A senior representative of a UN agency described the ubiquity of Pa Mon’s experience in northern Myanmar, and its impact: *“It’s simple things like using bathrooms. You [go to a camp] and see an older woman trying to wash herself in public, trying to protect her dignity. These are the things that matter. It’s not about food. People aren’t living with dignity. And the older you are, the worse it is.”*³⁷²

4.2 ESTABLISHED IDP CAMPS

In Kachin and northern Shan States, more than 105,000 people live in IDP camps, the result of almost a decade of conflict and abuse, after the ceasefire between the Myanmar military and the Kachin Independence Army (KIA) broke down in June 2011.³⁷³ Most of those currently in an IDP camp have been displaced and living in a camp for more than seven years.

In comparison to the Bangladesh refugee camps and to short-term displacement sites in Myanmar, the established IDP camps in northern Myanmar have infrastructure better designed for prolonged displacement—though many shelters are becoming dilapidated, due to the restrictions on humanitarian access.³⁷⁴ The IDP camps tend also to be small and on relatively flat terrain.³⁷⁵ As a result, while several older displaced people in northern Myanmar said there were challenges in accessing latrines during the rainy season, when the ground becomes slippery, in general the issues described in Chapter 3 were not the main concerns of older people in the IDP camps where Amnesty International undertook interviews.

Rather, older women and men in the IDP camps in northern Myanmar most often raised issues of discrimination and exclusion. Unlike the refugees in Bangladesh, people displaced internally in northern Myanmar can move around outside the camps and seek work.³⁷⁶ Older people, however, seem largely to be discriminated against for daily jobs, and to be excluded from, or underrepresented in, humanitarian programs on livelihood assistance. They also rarely have representation among camp governance structures, denying them a voice and role in decision-making.

As noted in the text box on page 61, this section focuses on older women and men among the almost 70,000 displaced persons living in IDP camps in government-controlled areas of Kachin and northern Shan States.³⁷⁷ Particularly in accessing adequate food, shelter, and health care, the situation is worse for older people living in IDP camps in non-government-controlled areas (NGCA) of Kachin State,³⁷⁸ in large part because of the Myanmar authorities’ severe restrictions on humanitarian access.

DISCRIMINATED AGAINST FOR CASH LABOUR

Almost a decade into the humanitarian response in Kachin State, the amount of in-kind or cash assistance provided to displaced people each month has declined considerably; the expectation is that people living in IDP camps can work as day labourers, for example on nearby farms.³⁷⁹ Many older people described being discriminated against in obtaining such work, primarily due to attitudes that see them as weaker. Such

³⁷¹ Amnesty International interview, Nalwe village IDP site, Shan State, Myanmar, 26 March 2019.

³⁷² Amnesty International interview, location withheld to protect anonymity, Myanmar, December 2018.

³⁷³ OCHA reported that as of March 2019, there are 169 IDP camps in northern Myanmar, with 97,265 IDPs in camps in Kachin State and 9,136 IDPs in camps in Shan State. OCHA, Myanmar: Humanitarian access in Kachin and northern Shan (as of March 2019), 7 May 2019.

³⁷⁴ Amnesty International interviews with humanitarian workers in Kachin and northern Shan States, Myanmar, December 2018.

³⁷⁵ In terms of size, the largest IDP camp in government-controlled areas has around 4,000 people, and the majority of the IDP camps house fewer than 1,000 people. See OCHA, Myanmar: IDP Sites in Kachin State (as of 28 February 2019), https://reliefweb.int/sites/reliefweb.int/files/resources/MMR_Kachin_IDP_Site_A0_Feb2019.pdf. Several camps in NGCA, including Sha-It Yang, which Amnesty International delegates visited in March 2017, are in mountainous areas; older people there with limited mobility would likely face some of the access challenges described in Chapter 3 related to the refugees in Bangladesh.

³⁷⁶ The freedom of movement for displaced persons in northern Myanmar is also in stark contrast to the situation of around 128,000 Muslims, predominantly ethnic Rohingya, who have been confined to camps in central Rakhine State since 2012. For more on the camps in central Rakhine State and the movement restrictions targeting the Rohingya, see Amnesty International, *“Caged without a Roof”*.

³⁷⁷ See OCHA, Myanmar: IDP Sites in Kachin State (as of 28 February 2019) (59,334 IDPs in government-controlled areas of Kachin State); and OCHA, Myanmar: IDP Sites in Shan State (as of 28 February 2019), https://reliefweb.int/sites/reliefweb.int/files/resources/MMR_Shan_IDP_Site_A0_Feb2019.pdf (9,136 IDPs in northern Shan State).

³⁷⁸ See OCHA, Myanmar: IDP Sites in Kachin State (as of 28 February 2019) (37,931 IDPs in non-government-controlled areas).

³⁷⁹ Humanitarian workers in northern Myanmar described several concerns that are beyond the scope of this report, including that people in the camps are typically paid a substantially lower daily rate than those from the host community—affecting the overall labour market and creating tensions between camp and host communities. Amnesty International interviews with humanitarian workers, December 2018.

discrimination, even when they have done related work their entire lives and remain physically able to do so, undermines their access to livelihoods and makes them dependant on the decreasing assistance.

After the resumption of fighting between the Myanmar military and the KIA in 2011, Zatan Hkawng Nyoï, 67, fled to Quarter #2 Lhaovo Baptist Church IDP Camp, in Waingmaw Township, Kachin State. (For more on Zatan Hkawng Nyoï's experience of conflict and displacement, see page 58.) Before being displaced, she worked for decades on her farm, cultivating rice, fruits, vegetables, and spices.³⁸⁰ But she said that when employers come to the camp to hire day labourers to work in paddy fields, they do not hire her, or other older people, because of her age and what they believe it signifies about her physical condition.

*"I've approached the employers and said I want to work," Zatan Hkawng Nyoï said. "They said I'm too old, that I won't be able to walk that far to [the paddy fields]... No one invites us older people [to work]... They say that type of work requires demanding physical condition."*³⁸¹

Amnesty International heard similar frustrations from other older women and men. A 63-year-old ethnic Kachin woman who had been a paddy and shifting cultivation farmer throughout her life said, of her experience in an IDP camp in Myitkyina Township, *"We don't work because we are old so there isn't anything for us."*³⁸² She said that, in her first years in the IDP camp, she had been hired to work as a cash labourer *"from time to time,"* but that for around two years, no one would hire her anymore.³⁸³

Two older displaced people whom Amnesty International interviewed said they could get some work during a brief time of year: the peak of the paddy harvest. A 65-year-old ethnic Kachin woman living in a different IDP camp in Myitkyina Township, who needed money to pay for her medications, said in December 2018 that she did *"some paddy harvesting around this time every year. They pay 5,000 kyats (US\$3) per day."*³⁸⁴ During the rest of the year, she said she relied on assistance from her children, as she couldn't get work.³⁸⁵

A 52-year-old ethnic Kachin man in Maina KBC Camp in Waingmaw Township who, in contrast to the older Kachin women and men Amnesty International interviewed, said he was able to get work in paddy harvesting and masonry *"around 10 days per month,"* described how the process works in his camp: *"The employers select those who are physically able. They either call me by phone or they come in [to the camp] and select people who want to work. They look at us and select who they want."*³⁸⁶

Although age is not among the grounds for which discrimination is prohibited by the Myanmar Constitution,³⁸⁷ the Ministry of Labour, Immigration, and Population has issued mandatory employment contract forms, under which discrimination on the basis of age is prohibited.³⁸⁸ Amnesty International has not determined whether the mandatory contracts apply to day labour like that which people in the IDP camps perform; if not, Myanmar should extend anti-discrimination protections to all forms of employment.

Under international human rights law, non-discrimination is part of the protection of all rights, including the right to work, in the ICESCR.³⁸⁹ Although age is not mentioned explicitly, the list of grounds is not exhaustive and extends prohibitions of non-discrimination to *"other status,"*³⁹⁰ which the Committee on Economic, Social, and Cultural Rights (CESCR), the expert body that monitors the ICESCR's implementation, has rightly interpreted to include age discrimination.³⁹¹ The Committee has *"stresse[d] the need for measures to prevent discrimination on grounds of age in employment and occupation"*³⁹² and said that *"the range of matters in relation to which such discrimination can be accepted is very limited."*³⁹³

³⁸⁰ Amnesty International interview, Quarter #2 Lhaovo Baptist Church Camp, Kachin State, Myanmar, 11 December 2018.

³⁸¹ Amnesty International interview, Quarter #2 Lhaovo Baptist Church Camp, Kachin State, Myanmar, 11 December 2018.

³⁸² Amnesty International interview, name of IDP camp withheld to protect anonymity, Kachin State, Myanmar, 11 December 2018.

³⁸³ Amnesty International interview, name of IDP camp withheld to protect anonymity, Kachin State, Myanmar, 11 December 2018.

³⁸⁴ Amnesty International interview, name of IDP camp withheld to protect anonymity, Kachin State, Myanmar, 11 December 2018.

³⁸⁵ Amnesty International interview, name of IDP camp withheld to protect anonymity, Kachin State, Myanmar, 11 December 2018.

³⁸⁶ Amnesty International interview, Maina KBC Camp, Kachin State, Myanmar, 12 December 2018.

³⁸⁷ *Constitution of the Republic of the Union of Myanmar* (2008), para. 348 ("The Union shall not discriminate any citizen of the Republic of the Union of Myanmar, based on race, birth, religion, official position, status, culture, sex and wealth.").

³⁸⁸ Example employment contract on file with Amnesty International, referencing a prohibition under law of any discrimination on the basis of age, among other grounds. See also Yuwadee Thean-ngarm, Nwe Oo and Sher Hann Chua, *Employment and employee benefits in Myanmar: overview*, 1 March 2019, <https://uk.practicallaw.thomsonreuters.com/6-620-2720> (accessed 29 April 2019); DLA Piper, *Guide to Going Global: Employment*, 2019, p. 263 (identifying prohibited grounds of discrimination, including age, in Myanmar labour law).

³⁸⁹ Universal Declaration of Human Rights (UDHR), UNGA resolution of 10 December 1948, Article 2 (non-discrimination), Article 23 (right to work); ICESCR, Article 2(2) (non-discrimination), Articles 6 & 7 (right to work).

³⁹⁰ UDHR, Article 2; ICESCR, Article 2(2).

³⁹¹ CESCR, *General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)*, 10 June 2009, paras. 15, 29. See also, for example, OHCHR, "Universal Declaration of Human Rights at 70: 30 Articles on 30 Articles - Article 2," 2018, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23858&LangID=E>

³⁹² CESCR, *General Comment No. 6: The Economic, Social and Cultural Rights of Older Persons*, 8 December 1995, para. 22.

³⁹³ CESCR, *General Comment No. 6: The Economic, Social and Cultural Rights of Older Persons*, 8 December 1995, para. 12. See also CESCR, *General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)*, para. 29.



An older ethnic Kachin woman sits in her shelter in Jaw Masat IDP Camp, Myitkyina Township, Kachin State, 10 December 2018 © Hkun Lat / Amnesty International

EXCLUDED FROM HUMANITARIAN LIVELIHOOD PROGRAMS

As the IDP camps in northern Myanmar have become the long-term home of tens of thousands of people, many humanitarian and development organizations have undertaken programs aimed at supporting livelihood opportunities, in part also to replace food and other humanitarian assistance, which has decreased in recent years.³⁹⁴ Older people in the camps appear to be largely excluded from these programs, as a result of their design and of discriminatory attitudes. None of the older people interviewed by Amnesty International had taken part in such a program, despite their ubiquity in some camps; several members of camp management committees recalled between four to six such programs in their camp in the prior year.

Mun Lat, a 39-year-old ethnic Kachin man and camp-in-charge of Tat Kone Church of Christ Camp in Myitkyina Township, Kachin State, said several humanitarian and development organizations had come to do livelihood-related programs, including on handicrafts, livestock raising, and business management. He expressed general frustration with how programs were carried out, with attention rarely paid to local market dynamics and little follow-up after the initial training is completed and relevant goods delivered. He felt *“it’s important to include older persons and persons with disabilities in any program that’s started, [as] it would improve their livelihoods,”* but said that, in practice, the livelihood training and assistance programs in the camp involved exceedingly limited, or at times no, participation of older people or people with disabilities.³⁹⁵

Brang Mai, an ethnic Kachin deputy camp-in-charge of Maina KBC Camp in Waingmaw Township, told Amnesty International that there had been trainings and financial support for weaving and sewing and for restaurant management. He said that the oldest participants in the livelihood programs he was aware of were in their 30s or 40s, and that most people selected were in their 20s.³⁹⁶

Mun Lat said much of the problem was with the training requirements and system of selecting participants. People have to be physically present throughout the trainings—which often last for several weeks, or at times even more than a month—usually in rooms that are not accessible for people with disabilities, an issue that disproportionately affects older people. *“The older persons who have disabilities, they have the biggest difficulties,”* he said. *“When organizations come here for livelihood trainings, they are not able to take part. We wanted them to participate in the training, but they couldn’t.”*³⁹⁷

³⁹⁴ Amnesty International interviews with representatives of humanitarian organizations, Myanmar, December 2018.

³⁹⁵ Amnesty International interview, Tat Kone Church of Christ Camp, Myitkyina Township, Kachin State, Myanmar, 11 December 2018.

³⁹⁶ Amnesty International interview, Maina KBC Camp, Waingmaw Township, Kachin State, Myanmar, 12 December 2018.

³⁹⁷ Amnesty International interview, Tat Kone Church of Christ Camp, Myitkyina Township, Kachin State, Myanmar, 11 December 2018.

Mun Lat said people who were illiterate also could not participate—even for programs without a clear link to or need for literacy—which again disproportionately affected older people. Some organizations had a one-participant-per-family rule, which he said typically resulted in families sending younger people.³⁹⁸

Amnesty International was told of several livelihood assistance programs for IDPs being led by Myanmar's Department of Social Welfare; many other programs involve the approval of the Ministry of Social Welfare, Relief, and Resettlement, which oversees humanitarian work in the country. The denial of reasonable accommodations to people with disabilities, among other aspects that exclude them, constitutes discrimination on the basis of disability under the Convention on the Rights of Persons with Disabilities, which Myanmar has ratified.³⁹⁹ Discrimination on the basis of age more generally runs afoul of protections established by Myanmar's Ministry of Labour as well as the country's obligations as a party to the ICESCR.⁴⁰⁰

Most livelihood assistance programs in the camps are led by local or international humanitarian organizations. Humanitarian principles call specifically for non-discrimination and impartiality in the right to receive humanitarian assistance, including on grounds of age and disability.⁴⁰¹ Amnesty International interviewed a program manager of a humanitarian organization running livelihood programs in northern Myanmar; he said half of their participants are people who self-identify as interested in developing a business, and the other half are selected through protection referrals, when specific risks to individuals' rights and needs have been identified. *"The big question is, does our system bring in older people who think they can do certain tasks,"* he said, after presented with Amnesty International's concerns. *"I don't know."*⁴⁰²

CASH SUPPLEMENT FOR SOME OLDER PEOPLE IN IDP CAMPS

For the almost 60,000 people living in IDP camps in government-controlled areas of Kachin State, the distribution of in-kind food assistance has been replaced by a cash transfer—something that most displaced people initially welcomed. Cash assistance has decreased in recent years, however, as donor funding for the humanitarian response in northern Myanmar has declined; donors deem that most adults without disabilities can find work in the surrounding community to supplement the assistance.⁴⁰³ As discussed above, employment options are limited, at best, for older women and men, even when they are physically able to undertake—and indeed have significant experience in undertaking—relevant work.

In some of the IDP camps Amnesty International visited in Myitkyina and Waingmaw Townships, humanitarian organizations were providing, or had previously provided, supplemental cash assistance to older women and men, as well as to other groups considered to be vulnerable, including people with disabilities and households with pregnant women or newborn children. The precise amount, and the age at which support began, varied from camp to camp, when such support existed.

In Tat Kone Church of Christ Camp in Myitkyina Township, for example, the regular cash assistance for food is 11,000 kyats (US\$7) per person per month; a household with an older person—defined as 60 years or older—or a person with a disability received 15,000 kyats (US\$10) per month for that person.⁴⁰⁴ Zatan Hkawng Nyoi, 67, in Quarter #2 Lhaovo Baptist Church Camp in Waingmaw Township likewise said she received 15,000 kyats per month, whereas her son received 11,000 kyats.⁴⁰⁵

In Maina KBC Camp in Waingmaw Township, a recently-finished program had provided an extra 10,000 kyats per month to households with a person who was 70 years or older.⁴⁰⁶ A 70-year-old ethnic Kachin man living in an IDP camp in northern Shan State described a similar program there, though said there was a maximum of one supplemental grant per household, so that if there were several older people in the same household, or an older person and a newborn child, the supplement was 10,000 kyats total.⁴⁰⁷

In other camps, including Mading Baptist Church IDP Camp in Waingmaw Township and Jan Mai Kawng (Catholic) IDP Camp in Myitkyina Township, older women and men interviewed by Amnesty International

³⁹⁸ Amnesty International interview, Tat Kone Church of Christ Camp, Myitkyina Township, Kachin State, Myanmar, 11 December 2018.

³⁹⁹ CRPD, Article 2 (Definitions), Article 5 (Equality and nondiscrimination).

⁴⁰⁰ ICESCR, Article 2(2) (non-discrimination), Articles 6 & 7 (right to work). See also CESCR, *General Comment No. 6: The Economic, Social and Cultural Rights of Older Persons*, 8 December 1995, paras. 12, 22; CESCR, *General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)*, para. 29.

⁴⁰¹ *The Sphere Handbook* (Fourth Edition), p. 30; ADCAP, *Humanitarian inclusion standards for older people and people with disabilities*.

⁴⁰² Amnesty International interview, location withheld to protect anonymity, December 2018.

⁴⁰³ Amnesty International interviews with displaced persons and humanitarian workers, Kachin and Shan States, December 2018.

⁴⁰⁴ Amnesty International interviews with Mun Lat, camp-in-charge, Tan Kone Church of Christ Camp, Kachin State, Myanmar, 11 December 2018; and with four older women and men living in the camp, Kachin State, Myanmar, 11 December 2018.

⁴⁰⁵ Amnesty International interview, Quarter #2 Lhaovo Baptist Church Camp, Kachin State, Myanmar, 11 December 2018.

⁴⁰⁶ Amnesty International interviews with Brang Mai, deputy camp-in-charge, Maina KBC Camp, Kachin State, Myanmar, 12 December 2018; and with three older women and men living in the camp, Kachin State, Myanmar, 12 December 2018.

⁴⁰⁷ Amnesty International interview, Lashio, Myanmar, 15 December 2018.

said they only received 11,000 kyats per month, without any supplement.⁴⁰⁸

Where implemented, older people described the cash supplement, while small, as helpful in allowing them to buy medication and food. Particularly given the age discrimination in daily labour, the supplement allows for some freedom from dependency on adult children—a relationship that appears to be assumed in humanitarian response, even though many older people live alone or are a head of household. Even for older people who live in the same camps as adult children, dependency is often described as putting older people's needs in conflict with their grandchildren's needs. *"My children have their own children,"* said a 76-year-old ethnic Kachin woman in a camp in Waingmaw Township, in words similar to many others. *"They can't generate enough money [from cash labour] to pay for them and [my husband and me]."*⁴⁰⁹

In implementing such programs, humanitarian organizations need to communicate better with older people about the longevity and conclusion of supplemental assistance. In Maina KBC Camp, several older people said in December 2018 that the 10,000-kyats-per-month supplemental assistance had lasted around six to 12 months, then ended abruptly. They said there was no communication from camp leadership or the organization running the program that the program would end—that they just stopped receiving the money.⁴¹⁰ When asked by Amnesty International, the deputy camp-in-charge said he had heard only that the supplemental assistance was a *"project-based program"* that ended.⁴¹¹ Programs of course end when funding ceases, but the failure to inform people puts them in a position of risk.

LIMITED ACCESS TO HEALTH CARE

Access to health care varies significantly from camp to camp. In Maina KBC Camp in Waingmaw Township, two nurses are present most days;⁴¹² in several other camps, older women and men said that nurses from Myanmar's rural health centre come weekly or every other week and that doctors come once or twice a month to treat people.⁴¹³ In other camps, however, older people said health professionals come only rarely and not according to any schedule they were aware of.⁴¹⁴ People are also allowed to go to health centres and hospitals outside the camps, though, in particular for people living in IDP camps outside urban areas, cost and distance typically mean such visits happen only in emergencies.

Older women and men said that, even when health professionals do come to IDP camps, they generally do not provide vitamin supplements or medicines needed to treat chronic conditions like diabetes and high-blood pressure; older people needed to pay for those medicines and supplements themselves from a market stand in the camp or from a pharmacy nearby. While paying for medication is the reality for people across Myanmar, displaced people often no longer have access to normal sources of livelihood, including their farmland. For displaced older people in particular, the lack of access to their farmland is compounded by discrimination in being hired for daily labour near the camp, as described above. As a result, several older displaced people in IDP camps in Kachin State described struggling to pay for needed medication.

Nding Htu Bu, a 65-year-old ethnic Kachin farmer from Awng Lawt village, Tanai Township, said she had lived in Jaw Masat IDP Camp since June 2018, several months after she was displaced from her village. She said her biggest challenge is *"financial difficulties. I'm old, so I have to get supplements and medicines all the time, but I don't have the money for that."*⁴¹⁵ She said that when she first arrived to Jaw Masat Camp, there were organizations that came to provide health care, but that it stopped after a month or two.

Back in her village, Nding Htu Bu made money by farming and ordered the medication she needed, including a vitamin supplement and injections for a nerve problem, from a pharmacy in Tanai town. Without work in the camp, she said she struggled to pay for the medication, which she linked to her worsening health. *"Here, I don't want to eat—I don't have an appetite,"* Nding Htu Bu said. *"I don't want to sleep, or even if I do, I never feel like I have enough. I am exhausted—any movement, and I get so tired."*⁴¹⁶

⁴⁰⁸ Amnesty International interviews, Kachin State, Myanmar, 10 and 11 December 2018.

⁴⁰⁹ Amnesty International interview, location of IDP camp withheld to protect anonymity, Kachin State, Myanmar, December 2018.

⁴¹⁰ Amnesty International interviews, Maina KBC Camp, Kachin State, Myanmar, 12 December 2018.

⁴¹¹ Amnesty International interview with Brang Mai, Maina KBC Camp, Kachin State, Myanmar, 12 December 2018.

⁴¹² Amnesty International interviews with Brang Mai, Maina KBC Camp, Kachin State, Myanmar, 12 December 2018; and with two older people living in the camp, Kachin State, Myanmar, 12 December 2018.

⁴¹³ Amnesty International interviews with older displaced women and men, Tat Kone Church of Christ Camp, Kachin State, Myanmar, 11 December 2018; and Quarter #2 Lhaovo Baptist Church IDP Camp, Kachin State, Myanmar, 11 December 2018.

⁴¹⁴ Amnesty International interviews with older people from Mading Baptist Church Camp, Kachin State, Myanmar, 11 December 2018; Jaw Masat Camp, Kachin State, Myanmar, 10 December 2018; and Hpai Kawng Camp, Shan State, Myanmar, 15 December 2018.

⁴¹⁵ Amnesty International interview, Jaw Masat IDP Camp, Kachin State, Myanmar, 10 December 2018.

⁴¹⁶ Amnesty International interview, Jaw Masat IDP Camp, Kachin State, Myanmar, 10 December 2018.



Nding Htu Bu, 65, sits in her shelter in Jaw Masat IDP Camp, Myitkyina Township, Kachin State, 10 December 2018 © Hkun Lat / Amnesty International

A 76-year-old ethnic Kachin woman in an IDP camp in Waingmaw Township said she had been diagnosed with high blood pressure and had to take medication for it regularly. She needed to buy medicine from a shop in the camp, but said she was unable to work and the supplemental assistance for older people had recently ended in her camp. Her husband, who she said had a severe physical disability that left him unable to use one of his legs, also needed to take medication daily and often had to go to the hospital. They received financial support from an adult daughter who lived in the camp, but at times it wasn't enough; the woman said that she went without her medication sometimes, as it was less essential than her husband's.⁴¹⁷

The majority of people in the IDP camps in northern Myanmar fled abuses, or the legitimate fear of abuses, by the Myanmar military. Nding Htu Bu, for example, fled the military's firing of artillery or mortar rounds into her village and was then trapped on a jungle path for weeks because the military blocked the main escape route; during that period, she injured her ankle (see page 23). Far from progressively realizing people's rights to work and to health, the Myanmar authorities are responsible across Kachin and northern Shan States for undermining people's access to their farmland and other sources of livelihood and for undermining their physical and mental well-being. As such, the Myanmar authorities have a particular responsibility to provide health services, including essential medications, in the IDP camps, in order to mitigate the consequences of its military's actions. The current programs fall short.

LACK OF REPRESENTATION AMONG CAMP LEADERSHIP

The formal IDP camps across Kachin and northern Shan States have, over the years, established governance structures, known as camp management committees. These committees typically include representation from the camp population, the host community, and, at times, the religious community managing the particular camp.⁴¹⁸ None of the eight camps visited by Amnesty International in December 2018 had concerted representation of older people on the camp committee, according to interviews with older people themselves, with members of camp leadership, and with humanitarian workers. Older women seem to be particularly marginalized from camp governance and decision-making.

⁴¹⁷ Amnesty International interview, location withheld to protect anonymity, Myanmar, December 2018.

⁴¹⁸ As one example, the camp committee for Maina KBC Camp in Waingmaw Township includes five displaced people in the camp, three people from the host community, and three people from the Waingmaw Baptist Association. Amnesty International interviews, Maina KBC Camp, Kachin State, Myanmar, December 2018.

A humanitarian coordinator of an organization providing assistance in camps in Kachin and northern Shan States told Amnesty International, “*Camp management committees are supposed to oversee the whole camp, but I haven’t specifically heard of representation of older people.*”⁴¹⁹ A deputy camp-in-charge of a large IDP camp in Waingmaw Township, Kachin State said the oldest person on his camp committee was 45 years old.⁴²⁰ A camp-in-charge of another IDP camp, in Myitkyina Township, likewise said there was no representation of older people on his camp committee, after expressing concern about how he could best meet the needs of older people living alone. “*There are households with older persons [that] don’t have anyone to take care of them,*” he said. “*They live by themselves, and I don’t know how to help them.*”⁴²¹

Several of the bigger IDP camps that Amnesty International visited had sub-committees, including on child protection; had representatives or groups that focused on women’s rights in the camps; and had representatives or groups that focused on younger people in the camps. Even in those IDP camps, there was no sub-committee or specific group focusing on older people’s rights and needs.

Neither the creation of a new sub-committee or group on older people’s rights, nor the systematic inclusion of one or more older people on a camp committee, will, on its own, address the issues outlined in this chapter or in the preceding chapter on the Bangladesh refugee camps. But it will better ensure that camp-in-charge officials like the one from Myitkyina Township cited above hear older people’s voices and their ideas for responding to their specific needs. It will also, as importantly, see and treat older people as resources and essential participants in the decisions being made for everyone living in the camps.



An older ethnic Kachin woman and her grandchild pass the time in a common cooking facility for IDPs at the Kutkai Downtown (KBC Church) IDP Camp in Kutkai, northern Shan State, Myanmar, 28 July 2017. © Minzayar Oo – Panos / Amnesty International

⁴¹⁹ Amnesty International interview, location withheld to protect anonymity, Myanmar, December 2018.

⁴²⁰ Amnesty International interview, location withheld to protect anonymity, Myanmar, December 2018.

⁴²¹ Amnesty International interview, location withheld to protect anonymity, Myanmar, December 2018.

5. CONCLUSION AND RECOMMENDATIONS

Older women and men from ethnic minorities across Myanmar have likewise suffered the military's heavy hand. During military operations, soldiers have shot older people as they fled their villages and fired shells indiscriminately that exploded on or near their homes. Older people in Myanmar indeed face particular risks. They tend disproportionately to remain behind in villages, either because of limited mobility or a heightened connection to their land, and, when found by soldiers, are at times detained, tortured, and even burned to death inside their homes. Older people also face heightened risks of injury, illness, and death when fleeing, worsened by the military's tendency to block escape routes and to severely restrict humanitarian access.

For older people from many ethnic minorities, including the Kachin and the Rohingya, oppression and displacement have not been a singular, recent experience, but rather defined their entire lives. Soldiers have repeatedly burned their homes, and have destroyed or stolen their belongings. Soldiers have repeatedly forced them to porter or undertake other labour, and have choked off access to their farmland or other work. Soldiers have repeatedly forced them to flee to the jungle for short periods, and to displacement sites for longer periods. Soldiers have also killed or raped their children and grandchildren, at times in front of them. Older women and men describe distress over the inability to build up their lives or to provide for their children's future. For older people across Myanmar, psychosocial harm has been both acute and chronic.

The extent and nature of the Myanmar military's atrocities is reflected in the scale of the humanitarian crises those atrocities have engendered. More than 910,000 Rohingya women, men, and children live in refugee camps in Bangladesh, some 740,000 of who were forced across the border as a result of military operations in August and September 2017 marred by crimes under international law including, as the UN has reported, possible genocide. Some 250,000 more people from ethnic minorities are displaced internally to IDP camps or to makeshift displacement sites across Myanmar, including more than 105,000 in Kachin and northern Shan States and at least 30,000 as a result of ongoing fighting in Rakhine State.

The humanitarian community's response to these crises has been impressive, in many respects, particularly given Myanmar's restrictions on access and the largely unprecedented scale, in such a short period of time, of Myanmar's deportation of the Rohingya population to Bangladesh. But older people are falling through the cracks. Despite focus in recent years on the importance of inclusivity and ensuring that humanitarian assistance reaches everyone, older people remain largely invisible, beginning with the collection of data.

Humanitarian assistance is being provided without sufficient attention to the rights of older people or to the physical barriers they face, often linked to disability and reduced mobility. The Bangladesh refugee camps, given the heat, the monsoon rains, and, above all, the hilly terrain, present acute challenges for many older people and people with disabilities. Assistance needs to be designed and monitored to respond to these challenges. Shelter and latrine construction should be guided by maximizing access for people with limited mobility. Health services should be more mobile, reaching those with limited mobility or who are shelter-bound. Camp clinics should maintain supplies of medications for chronic diseases like diabetes and high-blood pressure—or, when not in stock, refer people to clinics that can provide the necessary care and ensure the person can reach that clinic. And food assistance should consider the specific nutritional needs of older people and the difficulties they encounter in obtaining cooking material.

In addition to physical barriers, older people often confront attitudinal barriers in humanitarian response. They are discriminated against for daily labour and in livelihood assistance programs, as such programs

often insufficiently consider their skills and perspectives and deny reasonable accommodation to those with disabilities. Older people are too often perceived as being in a position of dependency on adult children or grandchildren—who will, it is assumed, communicate relevant information to them and provide support to fill assistance gaps—when, in reality, many older people in the Bangladesh refugee camps and in the IDP camps in Myanmar live alone or as the primary caregiver of grandchildren whose parents were killed or are in detention. Older people, and older women in particular, are also underrepresented in bodies involved in camp governance, meaning their voices are left out of decisions.

The humanitarian community, including donor governments, must do more to ensure that commitments on inclusion and leaving no one behind are reflected in the design and evaluation of all assistance. Inclusion necessitates an approach that responds to the rights of people with different needs and risks, including those associated with aging. It must begin at a humanitarian situation's inception, rather than when transitioning from emergency to protracted response. The humanitarian community should be commended for the steady improvements it has made to the living situation of more than a million people displaced primarily due to the Myanmar military's crimes. But older people's rights remain neglected and their needs underserved amid those improvements. And the delays have already come at too great a cost.

5.1 RECOMMENDATIONS

TO THE GOVERNMENT OF MYANMAR

ON HUMANITARIAN ACCESS

- Provide immediate, unfettered humanitarian access throughout the country, including to all areas of Kachin, Rakhine, and Shan States. Allow UN agencies as well as international and national humanitarian organizations to assess and monitor the needs of displaced persons and others in need and to deliver assistance to them without restriction;
- Ensure that unfettered humanitarian access is provided not just to IDP camps and makeshift sites in centralized areas of displacement, but also to host communities and to villages recently affected by conflict, in order to ensure that people who have remained behind, often including older people and people with limited or no mobility, can be accessed and assisted;
- Facilitate humanitarian actors in transporting people who have had to remain behind in conflict-affected areas, including older people and other people with limited or no mobility, to safer areas, including displacement sites or camps; and
- Streamline and standardize the process by which humanitarian and development workers obtain authorization to operate, including travel authorizations, and ensure in particular that a substantive response is provided within a reasonable period, taking into consideration that many groups are supporting populations at particular risk.

ON INCLUSION AND NON-DISCRIMINATION IN HUMANITARIAN ASSISTANCE

- Ensure that nurses and doctors in rural health centres visit IDP camps and makeshift displacement sites regularly, and that, among other supplies, they are able to provide medication and other appropriate health services for chronic diseases, including high-blood pressure and diabetes; and
- Ensure Department of Social Welfare-run programs for internally displaced people do not discriminate on the basis of age or disability. Examine livelihood assistance programs in particular, and ensure that they uphold the rights of people with disabilities, in line with the country's responsibilities under the Convention on the Rights of Persons with Disabilities, under which the denial of reasonable accommodation is itself discrimination on the basis of disability; and
- Provide to private employers clear guidance prohibiting discrimination against older people and people with disabilities, and enforce such prohibitions.

ON LAND AND THE RETURN OF DISPLACED PERSONS

- Guarantee the safe, voluntary, and dignified return of refugees, internally displaced persons, and communities to their prior places of residence where at all feasible or, through proper consultation and informed consent, to adequate alternative housing elsewhere in the individual's preferred

region, while ensuring the full participation of refugees and internally displaced persons, including women in particular, in the planning and management of their return or resettlement and reintegration and overall development of their region;

- Protect the land of displaced people from confiscation, including by private companies and individuals. Where land or property has been confiscated, ensure that people, including older people, have swift judicial recourse to an effective remedy that includes retaking possession of land or property and receiving relevant compensation, such as for lost earnings; and
- Respect the right of all refugees and internally displaced persons not to be subject to forcible return to or resettlement in any place where their life, safety, liberty, or health would be at risk.

ON JUSTICE AND ACCOUNTABILITY

- Cooperate fully with international efforts to investigate and prosecute individuals suspected of involvement in crimes under international law and other human rights violations, including those with command or other superior responsibility;
- Accede to the Rome Statute of the ICC, issue a declaration accepting the ICC's jurisdiction since 1 July 2002, and incorporate its provisions into domestic law;
- Amend the 2008 Constitution to bring the Myanmar military and Myanmar Police Force under the oversight of civilian courts, and ensure that offences involving human rights violations and crimes under international law are tried in independent civilian courts; and
- Ensure prompt, impartial, independent, and effective investigations into all allegations of crimes under international law and other serious human rights violations by members of the security forces. Where there is sufficient, admissible evidence, ensure those reasonably suspected of individual criminal responsibility, including command responsibility, are brought to justice in proceedings which meet international standards of fairness without recourse to the death penalty.

TO THE GOVERNMENT OF BANGLADESH

- Work with UN agencies and humanitarian organizations to ensure that assistance programs are designed and carried out in a way that is inclusive and that does not discriminate on the basis of age or disability, in line with international human rights law and humanitarian principles;
- Ensure in practice that older people and others with medical needs have the right of freedom of movement to access adequate medical care, including outside the camps when necessary;
- Examine the referral systems in place for the Rohingya population in the camps to ensure that decisions around whom to refer to Bangladesh hospitals are being done in an inclusive way based on need, and do not discriminate in practice against older people; and
- Work with UN agencies and humanitarian organizations to ensure that the dissemination of information, for example on changes to assistance or on how to resolve problems like being left off a distribution card, is carried out in a way that reaches the entire refugee population, with specific attention to those who are most at risk, including older people living alone and older people who are shelter-bound. Strongly consider, for example, expanding networks of trained volunteers in the camps who identify people at risk, proactively communicate information to them, and visit those people regularly to determine if there are gaps in assistance or other problems to bring to the attention of relevant service providers.

TO UN AGENCIES AND HUMANITARIAN ORGANIZATIONS

ON DATA COLLECTION, INCLUSION, AND NON-DISCRIMINATION

- Systematically collect, analyse, and report age-, sex-, and disability-disaggregated data on people in humanitarian situations. For age-disaggregated data, ensure reporting is more detailed than just the total number of people age 60 or older, for example by disaggregating the data into age brackets of 50-59, 60-69, 70-79, 80-89, and 90 years and older;
- Collect information on, and design assistance programs with specific attention to, older people who are living alone or as the head of a household (i.e., caring for children and/or grandchildren) in humanitarian situations, including in makeshift displacement sites and refugee and IDP camps;

- Ensure strict adherence to international human rights law and humanitarian principles on non-discrimination and impartiality in the design and implementation of all assistance, including livelihood trainings and assistance for people living in IDP camps in Myanmar, such that the rights to participation and dignity are respected for older people and people with disabilities;
- Ensure that changes in humanitarian assistance or in the way humanitarian programs are implemented are communicated effectively, taking into consideration issues related to older age, including isolation; visual and hearing impairment; and limited mobility, including being shelter-bound. Do not rely exclusively on the diffusion of information through designated camp or block leaders; through communication at centralized points, like schools and distribution centres; and through telecommunications or other technological means, like mobile telephone messaging apps, all of which some older people and people with disabilities may not have access to;
- Promote the inclusion of older people on formal and informal governance structures in camp environments, including on IDP camp management committees in Myanmar, in order to better ensure that older people's rights and concerns are included in camp decision-making and in consultations between humanitarian actors and the displaced population;
- Monitor all assistance programs for how they conform to humanitarian principles and commitments on inclusivity and non-discrimination, including specific attention to humanitarian programs' impact on the rights of older people and people with disabilities; and
- Ensure that any relocation of older persons within the refugee camps is done with their proper consultation and informed consent and does not leave them worse off in terms of access to water, food, sanitation, or health facilities, or leave them isolated from family and social connections within the camps or otherwise restrict their enjoyment of other human rights.

ON SEXUAL AND GENDER-BASED VIOLENCE

- Include women and men age 50 and older in sexual and gender-based violence (SGBV) prevention and response. End the practice of cutting off SGBV-related surveys and programs at the age of 49, as it systematically excludes older women and men from protections and programs important to the realization of their rights in situations of conflict and crisis.

ON WATER AND SANITATION

- Install new latrines with specific attention to placing them in areas as close as possible to shelters inhabited by older people, and in particular older people with limited mobility and/or disabilities. Ensure, in future contexts, that the construction of shelters and latrines is undertaken, from the beginning of a humanitarian response, with specific attention to older age and disability, in order to best realize the rights of all people to physical health, sanitation, and dignity;
- Install latrines, to the extent feasible, in areas that maximize the ability of people to walk on flat ground to reach them. Construct ramps and handrails where hilly terrain is unavoidable;
- Prioritise further installation of sustainable lighting within all the refugee camps so that older people and others can safely access latrines at night;
- Upgrade roads and pathways within the camps to ensure they are accessible to all people and sufficient to withstand monsoon and other weather changes;
- Where difficult to improve pathways and accessibility to latrines and water sources for older people where they are residing, consult them about possible relocation to improve their access to these facilities, in accordance with their specific needs and wishes;
- Standardize the installation of age-friendly features, including handrails on pathways to latrines and water sources and support handles inside latrines. In future humanitarian contexts, plan to the extent feasible for such age-friendly features to become standard from the earliest feasible moment, rather than as a part of the transition from emergency to protracted response;
- Ensure that people who are shelter-bound have access to dignified sanitation facilities. Establish, in cooperation with camp and local authorities, community support networks in the camps to assist those who are shelter-bound with the regular and proper disposal of their excreta; and
- Ensure, for people who are unable to access water points or to carry water jugs, that systems are in place to deliver them clean water daily, for example through networks of porters or volunteers within a camp. Give particular consideration to households in which older people are living alone or as primary caregivers, and to households with people with disabilities.

ON FOOD AND NON-FOOD ITEM ASSISTANCE

- Improve outreach, including through community networks that go shelter to shelter, to identify all older people who are unregistered or who, particularly in the Bangladesh refugee camps, are struggling with the transition to the new e-voucher system and make sure that they are registered for all relevant assistance and can access that assistance;
- Further develop networks of community volunteers in all camps to assist older people with limited mobility in obtaining distributions of food and non-food items. For some older people with limited mobility, this may involve assistance in walking to distribution centres and in transporting items back to their shelter. For other older people, particularly those who are living alone and entirely or largely shelter-bound, this should involve delivery of distributions directly to their shelter, with protection monitoring to ensure that such shelter deliveries have been made;
- Prioritize efforts to ensure that older people can have sufficient food and diet diversity, in accordance with their right to physical health and their specific nutritional needs. In particular:
 - In the refugee camps in Bangladesh, prioritize the transition of older people and people from other groups with particular nutritional needs and risks to the new e-voucher system that involves a cash transfer. Strongly consider, to the extent possible and in recognition of the humanitarian funding shortfall, increasing the cash supplement for households with older people, as exists in some IDP camps in Myanmar;
 - In the IDP camps in Myanmar, ensure that any changes, including the end of a funding cycle, for programs that provide cash supplements for older people are communicated clearly to all affected people as far in advance as possible; and
 - Ensure that, in future humanitarian contexts, the roll-out of assistance designed to improve diet diversity, consistent with culture, is part of planning from the beginning of a crisis and is implemented as quickly as possible, with priority given to people, including older people, with particular nutritional needs and risks.
- Prioritize the distribution of cooking gas equipment and adequate amounts of fuel for refugees and other displaced people who may face particular challenges in obtaining cooking fuel through other means, such as by collecting or purchasing firewood. By identifying and prioritizing assistance to individuals with particular needs and risks, including older people or people with limited mobility living alone or as the head of a household, humanitarian assistance will better meet principles of inclusivity and non-discrimination and help realize all people's rights.

ON HEALTH CARE

- Ensure that medication for chronic diseases, including high blood pressure and diabetes, is available and kept in stock in camp health facilities. In future humanitarian crises, assess medication needs early in the response and ensure needed medications, including for chronic diseases disproportionately affecting older people, are promptly available free of charge at clinics;
- In the Bangladesh refugee camps in particular, increase significantly mobile health services, to better respond to the rights and needs of people, including older people, with limited mobility or who are shelter-bound. Identify people in such circumstances and provide health services for them in their shelter or, alternatively, provide them with vouchers for transport to a camp hospital or clinic and, particularly for older people living alone, support to accompany them;
- Identify people, including older people, with limited mobility or who are shelter-bound and who need to take regular medication, and establish mobile health services that can do shelter visits to replenish the medication as needed and to check on their health;
- Include older people in psychosocial care programs and activities. Consider, in the design of such programs, particular ways older people disproportionately experience psychosocial harm, including the killing of children and grandchildren; the separation from home and land; and living through multiple displacements and acute episodes of oppression, with cumulative effects; and
- In the Bangladesh refugee camps, improve the referral systems among health providers within the camps, in particular so that when one camp clinic is unable to provide a person with adequate health care, including needed medication free of charge, the person is referred to another camp clinic with the relevant diagnostic equipment and medication and, for people with limited mobility, provided with transportation to the relevant clinic. In cases where no camp clinic is equipped to diagnose or treat a person, ensure all relevant information about the referral system to Bangladesh

hospitals is provided in a way that is inclusive and non-discriminatory, and work closely with the Bangladesh authorities to ensure that all people's right to access health care is respected.

TO DONOR GOVERNMENTS

- Significantly increase financial and technical assistance to help respond to the needs of the Rohingya refugee population in Bangladesh in accordance with priorities outlined in the Joint Response Plan (JRP), including in areas where the rights of older people are not being met, such as the WASH and health sectors. Funding should be timely, predictable, sustainable, and in support of both immediate and longer-term needs of Rohingya refugees in Bangladesh;
- Increase financial assistance to help meet the needs of the internally displaced population throughout conflict-affected areas of Myanmar;
- Ensure financial assistance to the Government of Bangladesh and to the Government of Myanmar, as well as grants to implementing partners, including UN agencies and humanitarian organizations, contain provisions on strict adherence to the principles of inclusivity and non-discrimination, including for older people and people with disabilities, and that assistance programs are monitored and evaluated to ensure they meet relevant commitments from the World Humanitarian Summit as well as from the *Humanitarian inclusion standards for older people and people with disabilities*;
- Increase pressure on the Myanmar authorities to end restrictions on humanitarian access across the country;
- Demand that implementing partners systematically collect and analyse age-, sex-, and disability-disaggregated data according to best practices, including smaller age brackets;
- Ensure that, in future humanitarian crises, the rights and specific needs of older people and of people with disabilities inform planning from the beginning of the humanitarian response;
- Strongly consider funding supplemental cash transfer programs for older people in the refugee camps in Bangladesh and, where such programs do not exist already, in IDP camps in Myanmar. Draw lessons learned from existing supplemental cash transfer programs for older people in some IDP camps in northern Myanmar, to inform the design and implementation elsewhere; and
- Strongly consider funding an oral history project that focuses on the lives of older people from ethnic minorities in Myanmar, including those on which this report focuses, given the vital communal memory and history they represent, and that threatens to be lost in the coming years.

TO THE UN SPECIAL RAPporteur ON THE HUMAN RIGHTS OF INTERNALLY DISPLACED PERSONS

- Strongly consider undertaking a research project on the rights of older displaced persons, with specific attention to the rights and needs of older people displaced both to established IDP camps and, during shorter-term displacements, to makeshift sites.

ANNEX I: UNHCR RESPONSE



UNHCR Bangladesh

Response to Amnesty International, 31 May 2019

> The below is a response to Amnesty International's 15 May 2019 Request for Information as part of its examination of Rohingya refugees, with a focus on the rights and needs of older men and women.

Part I: Population Data

How does UNHCR define an "older person" in the context of the refugee response in Bangladesh?

An "older person" is defined by UNHCR as a person aged **60 years old or more**¹. This definition is used for the Bangladesh response.

As part of its operations, does UNHCR systematically collect, analyse, and disseminate age-disaggregated data? If so, how, specifically, does UNHCR disaggregate data based on age (i.e., what specific age brackets are used)?

Yes, age disaggregation is required for any registration exercise. Governing registration standards² recommend that "in principle, refugees should be registered on an individual basis"³ with "date of birth (or age)"³ among the "basic information"³ to be recorded. Where individual registration is conducted, the recording of each individual's date of birth allows disaggregation by age by whatever criterion is required for a particular response (i.e. for primary school-age children (6-11), adolescents (12-17), Global Acute Malnutrition (6-59 months) and women of reproductive age (13-49), among others).

Where individual registration is not possible, a household-level preregistration is recommended as soon as possible from the onset of a refugee situation. During preregistration, minimum details of the head of a family are recorded, while other family members are disaggregated by sex and age in the following age brackets: 0-4, 5-11, 12-17, 18-59, 60+.

For Bangladesh, UNHCR population data collection has proceeded in two general phases:

1. **Family Counting:** At the outset of the influx, UNHCR did not initially have permission to conduct individual registration. Instead, working with its Government counterpart—the Refugee Relief and Repatriation Commissioner (RRRC)—it conducted a Family Counting exercise beginning in October 2017, which gathered sex and age disaggregated household level data (age disaggregation included those below 1 year, rather than 0-4). Data for the Family Counting was published online from October 2017 and is updated twice monthly at: https://data2.unhcr.org/en/situations/myanmar_refugees.
2. **Joint Government of Bangladesh-UNHCR Registration Exercise:** Since the June 2018 launch of the joint exercise, individual data initially collected by the Government of Bangladesh is now being updated and consolidated, including date of birth for each individual refugee. Additionally, the Registration collects solutions-related individual data and will lead to creation of a consolidated, unified database with comprehensive population data for protection, assistance, and solutions in Bangladesh. The registration process is ongoing in 6 registration centres across the refugee camps.

As part of its operations, does UNHCR systematically collect, analyse, and disseminate disability-disaggregated data? If so, how, specifically, does UNHCR disaggregate data based on disability?

Yes, the registration standards quoted above require the recording of "special protection and assistance needs" as part of basic information. The UNHCR *Guidance on the Use of Standardized Specific Needs Codes*⁴ standardise and mandate the collection of specific needs, including disability, "regardless of which format the operation records such accumulated data". The following disability related specific needs are collected:

¹ This is a UN agreed cut-off age, unless for a particular context, an earlier age is used or where exceptions are made depending on the individual's physical state. See e.g., WHO, *Definition of an older or elderly person*, <http://www.who.int/healthinfo/survey/ageingdefnolder/en/>

² The Executive Committee of the High Commissioner's Programme, *Conclusion on Registration of Refugees and Asylum-seekers No. 91 (LII) - 2001*, 5 Oct 2001, No. 91 (LII), <https://www.refworld.org/docid/3bd3e1d44.html>. On the basis of this recommendation, UNHCR published the *UNHCR Handbook for Registration*, Sept 2003, <https://www.refworld.org/docid/3f967dc14.html>, setting out registration standards.

³ Recommendation VI of the Conclusion.

⁴ Available at <https://emergency.unhcr.org/entry/251587/identifying-persons-with-specific-needs-pwsn>

- Visual impairment (including blindness)
- Hearing impairment (including deafness)
- Physical disability (moderate or severe)
- Mental disability
- Speech impairment/disability.

Severe physical disabilities and mental and speech impairments can only be recorded by specialised trained staff. Others may be recorded by staff with basic training, including in emergency preregistration.

For Bangladesh, UNHCR data collection of disabilities has proceeded in two general phases:

1. **Family Counting:** During the Family Counting, specific needs were collected at household level—recording whether there was a person with one or more specific need within a family. Disability was recorded at a category level (without the breakdown above). By 15 May 2019, about **8,460** families out of roughly **210,120 (4%)** were recorded as having at least one person with a disability.
2. **Joint Government of Bangladesh-UNHCR Registration Exercise:** Family Counting data is now being updated in the joint Registration Exercise, where individuals with specific needs are identified, assessed by Protection staff, and referred to specialized interventions when required, rather than being tallied within a family unit. Thus far, 33% of the population has been registered (about 290,300 individuals in 64,090 families). Of those registered, **2,030** individuals have been identified as having a disability.

As part of its operations, does UNHCR collect, analyse, and disseminate disaggregated data associated with vulnerability factors other than disability? If so, on which factors and how?

Yes, apart from disability-specific needs, over 65 additional vulnerabilities are collected under the following 11 categories:

- i. Child at Risk (10 sub-categories, including Child Parent, Child Spouse, Child Carer, and Child in Conflict with the Law)
- ii. Unaccompanied or Separated Child (5 sub-categories including Unaccompanied Child, Separated Child, and Child Headed Household)
- iii. Woman at Risk (3 sub-categories, including Single Woman at Risk).
- iv. Older Person at Risk (3 sub-categories: Single Older Person, Older Person with Children, Older Person unable to take care of self)
- v. Single Parent or Caregiver (3 sub-categories: Single Parent, Single Grandparent, Single Caregiver)
- vi. Disability (7 sub-categories as above)
- vii. Serious Medical Condition (7 sub-categories, including Mental Illness, Malnutrition, Chronic Illness)
- viii. Family Unity (2 sub-categories: Tracing Required and Family Reunification Required)
- ix. Specific Legal & Physical Protection Needs (20 sub-categories including Mixed Marriage, Detained in Country of Asylum, Detained in Country of Origin, Detained Elsewhere, At Risk of *Refoulement*)
- x. Torture (3 sub-categories including Psychological and/or Physical Impairment due to Torture),
- xi. SGBV (8 sub-categories including Victim/survivor of SGBV in Country of Origin, During Flight or in Country of Asylum).

While some sub-categories in (i)-(vi) can be recorded by staff with basic training, including during emergency preregistration, most of those sub-categories and all sub-categories (vii)-(xi) are assessed and recorded by specialised protection or medical staff and then recorded in UNHCR's refugee registration tool—proGres. Access to create, edit, or view specific needs in proGres is restricted through a system of user rights. Some categories of specific needs can be viewed only by senior protection staff.

For the joint Government of Bangladesh-UNHCR Registration Exercise, specific data is collected and viewed only by UNHCR staff to maximize refugee protection and ensure confidentiality; they are not part of the joint data fields.

How many older persons are living alone among the refugee population in the camps?

During the Family Counting, **~30,100** older persons were identified, with **8,500** families reported having an older person with a vulnerability, of which **787** older persons at risk were identified as living alone.

In the ongoing joint Government of Bangladesh-UNHCR Registration Exercise, of the 290,300 registered refugees, **10,120** have been identified as older persons, of whom **841** are recorded as living alone. **1,771** of those older persons were identified as having a vulnerability, of whom, **417** are living alone.

How many vulnerable persons are living alone among the refugee population in the camps, including older persons with vulnerabilities?

During Family Counting, **2,973** individuals with some vulnerability were identified as living alone (of whom **787** were older persons with vulnerabilities).

In the ongoing joint Government of Bangladesh-UNHCR Registration Exercise, of the 290,300 registered refugees thus far, **959** individuals with vulnerabilities have been identified as living alone (of which **417** are older persons with vulnerabilities).

How many older persons in the camps are acting as primary caregivers (for example, though not limited to, older people caring for grandchildren whose parents were killed during the military operations)?

During Family Counting, **4,647** families were identified as older persons at risk with children.

In the ongoing joint Government of Bangladesh-UNHCR Registration Exercise, of the 290,300 registered refugees thus far, **546** older persons with vulnerabilities have been identified as primary caregivers.

How many vulnerable persons in the camps, including older persons with vulnerabilities, are acting as primary caregivers?

In the ongoing joint Government of Bangladesh-UNHCR Registration Exercise, of the 290,300 registered refugees thus far, **5,946** persons with vulnerabilities have been identified as primary caregivers (of whom **546** are older persons with vulnerabilities).

Under the Government of Bangladesh's leadership, a unique coordination structure distinct from the traditional UNHCR-led Refugee Coordination Model (RCM) has governed the Rohingya response in Bangladesh since late 2017.

UNHCR co-chairs a Strategic Executive Group (SEG) with IOM and the UN Resident Coordinator in Dhaka. In Cox's Bazar, oversight of various "sectors"—10 sectors, 2 sub-sectors, 2 working groups, and an NGO platform operate under the Inter Sector Coordination Group (ISCG) in Cox's Bazar—which is divided among UN agencies, mainly with staff from UNHCR and IOM. Of the sectors, UNHCR only leads the Protection Sector, and co-chairs the Gender in Humanitarian Action (GiHA) working group. Nevertheless, UNHCR's interventions across all sectors remain substantial, particularly as we try to mainstream protection throughout the response.

As a result of this coordination arrangement, camp management, technical implementation, and protection programming has been divided between UNHCR and IOM. UNHCR manages 16 of 34 camps and has over the course of 2018-2019 expanded protection responses in some IOM-managed camps. Where references are made below to UNHCR's area of responsibility (AOR), they are addressing these UNHCR-managed camps.

A review of the coordination structure for the Rohingya response was conducted in late 2018 and recommendations have been made to, among other changes, try to ensure a more accountable response. At the time of writing, the recommendations remain under implementation.

Part II: Community Consultation and Engagement

The below addresses the following questions raised by Amnesty International:

- How has UNHCR consulted with older Rohingya women and men as part of the humanitarian response? In what ways, if any, does UNHCR think the humanitarian response could improve in its consultation and active involvement of older refugees?

- *How has UNHCR consulted with Rohingya women and men with vulnerabilities? In what ways, if any, does UNHCR think the humanitarian response could improve in its consultation and active involvement of refugees with vulnerabilities, including older refugees with vulnerabilities?*
- *What programs, if any, exist for helping people with limited or no mobility, including older people with limited or no mobility, in accessing food distributions and adequate drinking water?*
- *When UNHCR needs to communicate a change in assistance to refugees, or needs to otherwise get information disseminated to the refugee population, what is its standard practice for doing so?*

Age, Gender, Diversity (AGD) Inclusive and Protection Mainstreamed Programming

In November 2017, early in the onset of the Emergency, UNHCR undertook a community assessment of Rohingya refugees in Bangladesh, conducting focus group discussions (FGD) with 522 refugee women, men, children, older persons, and persons with disabilities, as well as 25 community leaders, to better understand their most pressing concerns, needs, and priorities. **Of those interviewed, 10% were older women and 11% were older men** – with the age threshold of 50 and above, for purposes of this specific assessment, given the average life expectancy of 66 years old. The findings of this assessment informed UNHCR programming, which thus focused on:

- Ensuring **independent and equitable access to information** for all refugees, according to their preferred communication modalities;
- **Identification of persons at heightened risk**—persons with specific needs who require additional support and interventions—and referring and/or accompanying them to service providers;
- **Supporting refugee volunteers** who implement self-identified/prioritised activities to respond to the community's most pressing needs; and
- **Establishing safe and inclusive integrated community spaces** where refugees can obtain information, lodge complaints, provide feedback, and participate in social and recreational activities.

Equitable Access to Information and Accountability in Service Delivery to Refugees

UNHCR offers diverse communication channels within its programmes to cater to the varied needs of a resilient community with low levels of literacy, compounded by mobility restrictions for some groups due to social norms and physical challenges. These information channels are concurrently paired with referral networks and direct support to refugees, facilitating better access to services.

1. **Community Outreach.** Specifically for persons with disabilities and older persons who may be shelter bound, door-to-door outreach by trained refugee Community Outreach Members (COMs) ensures that refugees have independent and equitable access to key, lifesaving information. Given that face-to-face outreach remains the preferred method of interaction, refugee outreach volunteers conduct block-based sessions/awareness raising campaigns in public spaces (Community Centres, Child and Women Friendly Spaces, markets, mosques) using audio, visual, and verbal communication channels.

In providing direct support to refugees, the COMs accompany refugees to service providers, notably health facilities, organising stretchers for those needing.

While refugees age 18-30 tend to dominate outreach activities, the work of 1 COM over age 50 was showcased in the 2018 UN International Day of Older Persons, expressing appreciation for the capacity building opportunities, positive experiences working with dynamic younger refugees, and helping his community access healthcare and services.

From 2018 to date, the refugee COMs programme in 12 Camps—implemented by UNHCR partners Technical Assistance Inc. (TAI) and BRAC—conducted:

- **41,679** home visits reaching **140,186** refugees (66,556 men, 73,630 women)
- **40,544** awareness raising sessions for **657,125** refugees (329,897 men, 327,228 women) on health and hygiene; anti-trafficking; emergency preparedness for natural hazard; women's empowerment and SGBV prevention; peace in the home; distress and mental health; security; and information on the Memorandum of Understanding between Myanmar, UNDP, UNHCR.

> As a result of those interventions, **36,859** persons with specific needs (including elderly at risk) have received information, **3,833** were accompanied to service providers, and **8,328** were referred to other outreach volunteers and UNHCR partners.

This year, COMs have reached over **45,000** women and men of all ages with extensive information on the joint Government of Bangladesh-UNHCR Registration Exercise while recording queries and reporting on community concerns/anxiety.

> With improved disaggregated data tracking since March 2019, **1,118** refugees aged 45-59, and **731** refugees aged 60+ have received home visits, participated in awareness sessions, or were referred for assistance/additional support, while **168** older persons were classified as urgent cases. As the COMs programme develops through continuous capacity building of COMs and analysis by UNHCR/partners, harmonised disaggregated data reporting will further improve.

2. **Information Service Centres.** UNHCR and its partners also operated **15** Information Points serving **99,130** refugees in 2018, of which **4%** were over age 60, attending to the needs of **12,714** refugees with specific needs, some **3,000** of whom were referred for urgent interventions. In 2019 so far, **1,163** refugees (492 women, 671 men) aged 60+ comprised **6.4%** of refugees approaching Information Service Centres (previously 'Information Points'). Elder refugees' top concern has centred on core relief item (CRI) distribution. Details of visits and complaints are digitally recorded via KoBo application to map refugee demographics approaching Information Service Centres and analyse gaps in service provision and vulnerability trends.

In addition to the above, UNHCR continues to prioritise medical, rehabilitative (i.e. assistive devices for those with disabilities), and psychosocial services, as well as protection interventions. In 2018, **3,669** older persons and disabled refugees were accorded with targeted support and **4,750** received psychosocial assistance.

Refugee-led Solutions and Resilience Building

UNHCR's community-based approach builds on refugee capacities, with programmes harnessing community spirit and solidarity while continuously offering capacity building activities to strengthen agency and skills. To that end, UNHCR's refugee outreach, volunteers, and Community Representation programmes emphasis participation of refugees from diverse backgrounds, where close to 40% of refugees directly involved in outreach, service projects, and elected camp Committees are women. Programmes encourage participation of refugees who are passionate and dedicated to serving their community, irrespective of age, literacy levels, and academic qualifications. Among others, major programs include:

1. **Community Volunteers.** COMs, discussed above, are paid, trained refugees who conduct door-to-door/block-based outreach, awareness raising, and direct community support and referrals. Roughly one-third of COMs are women, facilitating outreach on sensitive issues. **In addition, refugee Safety Unit Volunteers (SUV) and Community Health Workers (CHW)** further drive community-led resilience and support. On average, COMs and SUVs receive equivalent monthly compensation (SUVs are paid per days worked), while CHWs receive more due to their specialization.
2. **Community Groups.** The Men, Women, and Youth Community Group programme implemented by partners TAI and BRAC is a unique initiative supporting unpaid refugee volunteers to identify the community's most pressing concerns and conduct self-initiated service projects.
 - In 2018, **>1,000** Community Group members completed **365** projects (averaging 1 per day), most addressing site improvement issues and shelter repairs in response to needs of refugees with mobility challenges (older persons, people with disabilities, small children, pregnant women).
 - Between January-May 2019, partner staff estimate over **27,000** older refugees directly and indirectly benefited from nearly 500 community service projects (community led discussions, road repairs, bridge building, vegetable gardens) in **17** camps.
 - Within the **51** Community Group members, **255** refugees (22.4% of the 1,137 members) are aged between 50-59 years, and **63** refugees (5.5%) are aged 60+.
3. **Caregiver Groups.** Recognizing the mobility challenges and potential isolation of older refugees, UNHCR's Child Protection programme is expanding its intervention through establishment of **29 Caregivers Groups and 13 Committees composed of elderly caregivers.** Group members will

have the opportunity to share their skills at child friendly spaces (CFS) and within mobile activities while participating in programme design. This initiative allows community members to fully engage in the CFS and build on traditional support: Children attending CFS and **300** elderly people will benefit from intergenerational exchanges and positive transfer of experience and knowledge. These joint activities will mitigate their isolation, value experience and skills, and strengthen community ties through the preservation of cultural and social identity.

4. **Integrated Community Centres.** UNHCR and its partners endeavour to support community spaces offering an array of activities for all refugee groups – **12 Integrated Community Centres** offer social, recreational, and skills training programmes based on community priorities and social/cultural norms, promoting inclusive refugee participation across ages and abilities. Women-only days at Community Centres have afforded safe spaces for women and girls of all ages, including older women, to participate in skills training (tailoring) and radio listening activities.
5. **Elected Community Representation.** Rolled out in 4 camps thus far, **elected Block and Camp Committees** include 12 refugees (8 men, 4 women) between age 50-60—**8.5%** of the elected Community Representation structure.

Meaningful Participation in Decision Making and the Public Sphere for All Refugees

UNHCR consistently engages all refugee groups, including older men and women, and people with specific needs to analyse the Protection situation in the Camps and inform programming. This includes:

- **Participatory discussions** with male and female refugees of all ages and abilities throughout the programme cycle (i.e. periodic consultation on preferred Community Centre activities; WASH/Shelter team consultations with women and girls on longstanding challenges of bathing and toilet facilities)
- Facilitating **regular (weekly/monthly) discussions with refugee Community Groups and elected Camp Committees** to understand the community's main concerns and support proposed solutions;
- Refugee complaints captured during **door-to-door outreach** and at **Information Service Centres**;
- **Protection monitoring** via sensitive community discussions, discreet key informant interviews, etc
- **Post Distribution Monitoring**, where in September 2018, 9% of respondents were aged 60+, and **Multi-Sector Needs Assessments** in July 2018 and January 2019 with 1% of respondents aged 65+
- **Understanding community coping mechanisms** in preparation for monsoon/cyclone. In May 2018, refugee COMs interviewed **1,120** refugee households regarding knowledge of weather patterns and household contingency plans, in tandem with information/sensitisation sessions on emergency preparedness. In May 2019, a series of FGDs are ongoing to assess how refugees are preparing for the monsoon and cyclone, based on responses of the 2018 survey.

UNHCR is cognisant that persons with disabilities and the elderly are disproportionately challenged and impacted vis-à-vis access to and quality of basic services, and during a crisis/emergency. Community concerns and feedback are shared with UNHCR Site and Technical Units, partners, and service providers, while Protection issues are sensitively addressed via referrals pathways and case management protocols.

Part III: Accessibility – Physical Infrastructure

What factors have gone into deciding where to construct new latrines? What specific attention has been paid to older age, vulnerability, and disability in selecting locations for latrines—in particular to maximize access? What limitations are there, for example as a result of the camp terrain and other environmental factors, when determining feasible locations for latrines?

Since the August 2017 influx, latrines construction across camps has proceeded in a phased approach.

Given the suddenness, scale, and rate of the August 2017 influx, the Rohingya refugee settlements in 2017 and early 2018 were **predominantly self-settled, with no pre-emptive site planning**. Consequently, the sites—sitting atop hilly terrain and loose soil—became highly haphazard and congested, with the yearly monsoon and cyclone seasons posing risks to refugee life and infrastructure.

At the outset, absent any WASH facilities in the emerging Cox's Bazar camps, UNHCR focused on ensuring **installation of basic facilities to mitigate risk of communicable disease and to promote general**

hygiene and dignity, while also operating in a humanitarian space oversaturated by WASH actors installing facilities with limited coordination. Consequently, the emergency target of 1 latrine per 50 individuals was initially set, with latrines installed wherever possible in the rapidly emerging and evolving camps.

Following the immediate response phase, UNHCR shifted in 2018 to a macro-planning approach to latrine and WASH facility placement, taking into consideration camp-by-camp demographics, density, terrain, and other related variables. However, due to the high concentration of individual single-story shelters and other infrastructure, available land within the camps is extremely scarce, particularly for the revised approach of **1 shared latrine per 20 individuals**.

As the operation moved into 2018, UNHCR **iteratively upgraded latrines** with larger volume pits. Additionally, UNHCR worked with the Government of Bangladesh to **reduce the density of the camps** as well as **relocate refugees** from areas prone to landslides or flooding to those with improved shelter models and planned infrastructure, including WASH. UNHCR **decommissioned 8,000 latrines** in flood prone areas, with an additional **1,000** slated for decommissioning in 2019. All facilities being replaced or retrofitted should pass through a **refugee community consultation** process to ensure issues with siting, access, and density are best resolved in accordance with community input, with special attention paid to age, gender, and diversity (AGD) concerns, including disability and other physical mobility issues.

Additionally, during 2018/2019, UNHCR commissioned and participated in multiple assessments; studies; and Knowledge, Attitude, and Practices (KAP) surveys focused on WASH facilities to better respond to the **concerns of all refugees**, including women and girls, persons with specific needs, older people, vulnerable groups, and those with disabilities. UNHCR is now implementing those recommendations where possible.

UNHCR, with our partners, is also working with Community Groups and engaging with refugees across the AGD spectrum to:

- Consult on siting of new facilities to reduce the distance between latrines and the most vulnerable;
- Maintaining and improving access to WASH facilities;
- Adapting latrines and bathing facilities to the specific needs of individuals across the AGD spectrum;
- Supporting standardization of adapted designs to meet the specific needs of individuals, and;
- Adapting designs to meet the specific needs of women and girls.

As infrastructure and siting are only one solution, UNHCR continues to explore more dignified, home-based solutions for the most vulnerable or mobility challenged.

What plans exist for improving lighting in the camps, particularly on pathways around latrines?

In 2017, 1,000 solar street lights were deployed rapidly as camps were established. To date, UNHCR has distributed **53,000 portable lights** to households, with intended full coverage within UNHCR's area of operation reaching **118,000** households.

Additionally, **900 free-standing solar street lights** have been installed across 16 camps in UNHCR's AOR and host community areas, with an additional **100** pre-positioned ahead of the monsoon season. To supplement these installations, UNHCR in 2019 received an additional **1,000** solar street lights from the Asian Development Bank (ADB) to be installed this year. Complementing these efforts, the Government of India will be installing **500** solar street lights in Camp 4.

Concurrently, UNHCR will receive 25 mini-grids from ADB, each powering 40 solar street lights (**1,000** total) for 10 hours in camps and boundary areas with the host community, as well 500 stand-alone solar street lights from the World Bank.

As part of the UNHCR's initiative on livelihoods and energy, an additional **2** solar mini-grids will be completed by the end of 2019 in Camp 4 extension, providing lighting to **400** shelters total, as well as market places, pathways, and latrines. The ADB will further provide lighting to **7,500** families in Camp 4 extension.

For 2020 and 2021, UNHCR projects installation of **5-8** solar mini-grids per year, with all designs incorporating a public lighting element to address protection issues. Maintenance and cleaning of all of the above is covered by paid refugee Safety Unit Volunteers.

Recognizing that lighting around latrines provides both security benefits and risks—including creating congregation points for individuals that may pose an additional threat to predominantly women and girls—

the above plan of free-standing solar lights for families and solar mini-grids aims to promote night time dynamics centred around lighted spaces that are more robust, dispersed, and realistic across the camps.

In constructing new shelters and moving people to new shelter locations, what consideration is given to the rights and needs of older people? What consideration is given to various vulnerability factors?

For new shelter construction or repair, the elderly or disabled are given **full labour support** for construction and support by porters for carrying distributed materials as needed by refugee volunteers facilitated by UNHCR, through partners.

During 2018, when some land was still available across some camps, focus was placed on relocations for households in shelters at risk of natural hazards. In the development of this plan, UNHCR, as part of the Site Management Sector, has operated under the April 2018 **Standard Operating Procedure for Relocations**, which, among other listed principles and pre-conditions, stresses that:

- All relocations must be **voluntary, safe, dignified, and informed**, except in cases of security or protection concerns (for which Protection and Site Management will engage)
- The principle of **"Do No Harm"** must be upheld, including recognition that refugees with specific needs must be identified and addressed before, during, and after relocation to ensure equal access to services (i.e. women/child-headed households, single male parent households, single older person head of households, unaccompanied children, persons with disabilities (or mobility constraints) and older persons without support)
- Relocation must ensure **adequate shelter and WASH facilities** and **access to health services and food distribution** in location of arrival, with consideration for persons with specific needs.

To this end, 72 hours prior to relocation, **protection screenings** are conducted to ensure that vulnerable refugees are properly identified (including persons with reduced mobility), relevant referrals and case transfers are made (with special care given to data protection), and vulnerable refugees are properly informed. For the relocation itself, special attention is paid to ensuring that the identified route is easiest for walking and that **transport support** is available for the elderly and those with mobility restraints.

At the relocation site, shelter partners construct shelters in advance for pre-identified families, with plots for vulnerable refugees (including the elderly and those with mobility restrictions) **allocated near access routes, WASH facilities, and health facilities**. Emphasis is also placed on ensuring that vulnerable persons remain with their relatives/support system, and on avoiding grouping vulnerable individuals or families. On arrival in relocation sites, persons with reduced mobility are supported to reach their new shelters if such plots are far from the disembarkation and registration area, with **stretchers** on standby.

In 2019, as both lateral and vertical expansion is now limited, UNHCR now focuses on **mitigation of risks** in-place, strengthening shelters as much as possible at the household level. To do so, the same general principles for relocations are upheld, with Protection teams engaged in identification and support to vulnerable persons, including the elderly and those with disabilities.

Concurrently, UNHCR through its partners continuously focuses on **increasing accessibility** by developing the motor-able network throughout the camp. This includes including ongoing construction of bamboo bridges, pathways, and stairs, as the hilly topography of the camps pose many obstacles to people with limited mobility. The paved footpaths, as much as possible, are designed without steps (despite the terrain) in order to facilitate the movement of local light electronic vehicles (so-called 'tom-toms' and CNGs).

In the few instances where space is available for new shelters, UNHCR tracks the receiving capacity per camp, highlighting numbers of at-risk households in danger of adverse effects of floods and landslide by Camp. Additionally, in cases where households need to be relocated due to construction of new infrastructure, identification and support to elderly or disabled persons is prioritized.

What programs, if any, exist for helping people with limited or no mobility, including older people with limited or no mobility, in accessing food distributions and adequate drinking water?

While food distribution is covered by WFP, UNHCR regularly distributes a range of non-food items, including Liquefied Petroleum Gas (LPG) for cooking, core relief items, etc. Given the present configurations of the

camps, those with mobility restrictions, including older persons and the disabled, may have difficulty accessing distribution points, waiting in queues, and/or carrying back received items. In an effort to increase accessibility and protection mainstreaming, the following systems are in place:

- **Porters:** For refugees able to reach distribution points, UNHCR commissions a porter system by which refugee volunteers carry received items to the beneficiary's shelter, reducing the strain on those with vulnerabilities or mobility constraints.
- **Informal community-led volunteers:** For refugees unable to reach distribution points and water points due to mobility restrictions or other vulnerabilities, access and service delivery remains an ongoing issue, although an **informal, refugee-led system** to acquire and carry items is operational. Identification of need may be conducted by COMs, Community Groups, or other volunteers.
- **Accommodations:** Recognizing that a refugee's visit to a distribution point can be time consuming, hot, and possibly accompanied by children—an added strain for older persons, the disabled, single parents, or otherwise vulnerable refugees— UNHCR has installed **shaded areas, benches, latrines, and child play spaces** to mitigate some of these concerns during distribution.
- **Gender segregation:** Finally, recognizing protection concerns that can arise during distribution, UNHCR has implemented **gender segregated queues** for men and woman at distribution points.

Part IV: Accessibility – Medical Referrals and Services

What minimum standards exist for clinics and other medical facilities operating in the camps, and when were these standards adopted? In particular, what minimum standards exist around the stocking of medication for chronic conditions like high blood pressure, diabetes, and chronic respiratory illness like asthma?

The *Minimum Essential Package for Essential Health Services* in refugee camps was developed jointly by Health Sector partners in November 2017 and revised in December 2018, both documents endorsed by the Ministry of Health. The document defines the level of services offered in health posts and primary health care centres (PHCs). Management of non-communicable diseases (NCDs) should accordingly be available at health post and PHC level. Advocacy and promotion to reduce NCD risk factors, and diagnosis and management of NCDs, are two further essential elements in the essential service package.

However, as the Health Sector is in a transition phase from emergency to protracted, the level of implementation of NCD care reflected above varies from partner to partner. UNHCR **procures essential medicine** through international procurement, which includes medicine required to manage Diabetes, Hypertension, Respiratory issues, as well as Mental Health Issues. Treatment for these conditions is available in all UNHCR-supported health facilities.

Emphasis of the health sector with the support from the IOM and UNHCR designated camp health focal person will be to monitor the quality and service provided by partners in the camps, in line with Joint Response Plan (JRP) commitments.

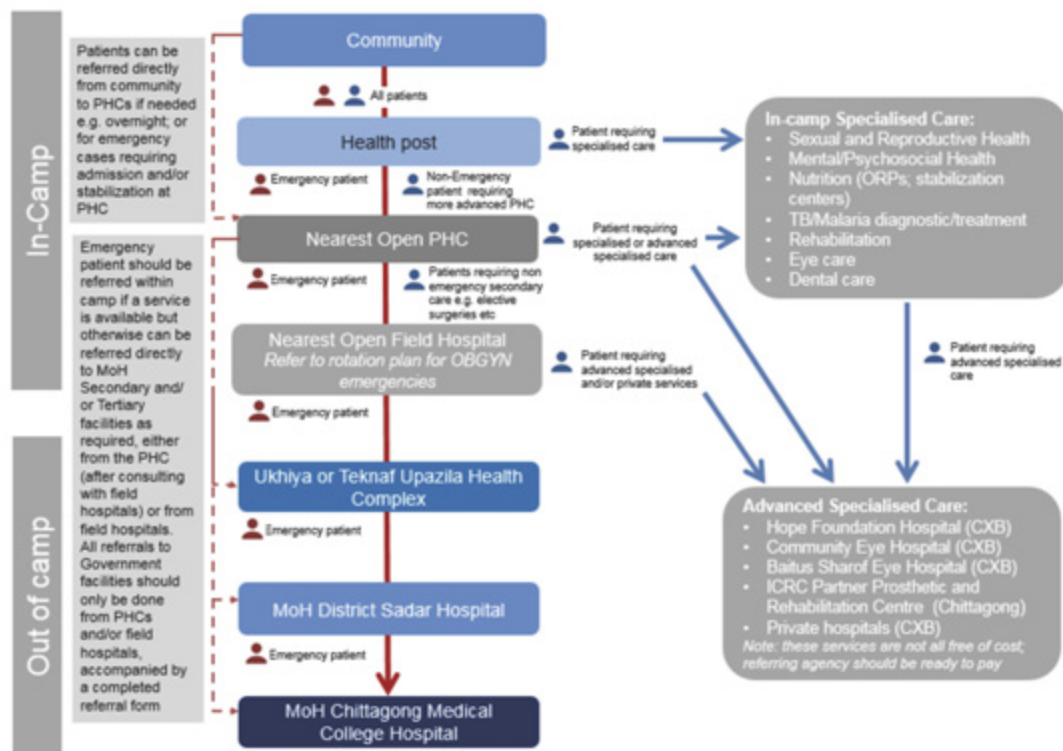
What referral system and standards exist within the camp medical response? For example, if one camp clinic is unable to diagnose or treat a person, including through providing appropriate medication, what is the protocol for referring that person to another camp clinic that could diagnose and treat the person? If a person with limited or no mobility needs to be referred, what is the protocol for ensuring that person can access the appropriate clinic?

The referral system in the health sector is governed by a **medical referral standard operating procedure (SOP)** which is approved by the Ministry of Health (MoH). In addition, standards for referrals through Primary Health Care Centres (PHC) are detailed in the *Essential Minimum Package for Essential Health Services* of the Health Sector, approved by MoH.

Within the refugee camps, health posts will refer to PHCs which operate 24/7 and offer a wide range of primary health care services. In addition, specialised services for e.g. eye care, dental care, or care for the elderly exist in camps, and health facilities will refer to those for further treatment. Moreover, camp-based field hospitals with larger treatment capacity accept patients from other camps in need of secondary health care (see flow chart below).

For those in need of health care services unavailable in the camps, patients in UNHCR-supported camp health facilities are referred to **government health facilities** in Ukhiya, Teknaf, Cox's Bazar, and Chittagong with ambulance transport support. All associated medical and non-medical costs are covered by UNHCR. Recognising that not all PHCs and health partners offer this service, leaving refugees in need unattended, UNHCR and IOM expanded the referral system in April 2019. Referrals for life-threatening medical, surgical, paediatrics, and obstetric/gynaecological conditions are supported by the two organisations in their respective area of operation, ensuring that all lifesaving referrals are supported.

Multiple **referral transport methods** operate in the camps based on a refugee's proximity to a health post and level of disability, as well as the operations of various health partners. These include: ambulance transport, three wheelers or compensation for three wheelers, and porters to carry patients.



What challenges exist in improving the referral system to Bangladesh hospitals, when camp clinics are unable to provide adequate medical care? In particular, what steps are being taken to ensure that people in need of medical care outside the camps are able to access that care?

Increasing demand for services poses the greatest challenge to referral facilities, and the Health Sector has advocated with donors and government secondary and tertiary referral facilities to bolster staffing, logistics, and infrastructure to meet increased demand. At present, health partners pay costs of referral (medicine, laboratory testing, food and transportation) to ease the burden of government facilities. Additionally, as noted above, UNHCR and IOM expanded their referral service to ensure that all lifesaving referrals are covered through financial and transport means. Nonetheless, referrals for non-urgent conditions are currently only partly covered through several organisations including UNHCR.

In 2019, UNHCR plans to support infrastructure improvements to the major hospital in Cox's Bazar which will result in additional space for in-patient and outpatient treatment. The Health Sector engages closely with the Ministry of Health as well as the World Bank to expand health-related projects in the district.

What plans exist for making the medical response more mobile, including through providing assistance, where necessary, in people's shelters (e.g., for people with limited mobility or who are shelter-bound)?

The *Essential Health Service Package* advocates for a minimum standard of one HP for every 10,000 individuals and one PHC for every 25,000 individuals with quality access. In addition to ensuring this general standard, the Health Sector is undertaking a **rationalization exercise of all existing health facilities** in the camps to ensure the geographic distribution maximizes accessibility across all camps.

Facility-based health care is supported by refugee Community Health Workers (CHW) who provide promotive and preventive health messages, ensure timely referral to appropriate health facilities, and support epidemiological surveillance. At present, approximately **1,800** CHWs are active, of which **300** are supported directly by UNHCR. UNHCR chairs the Community Health Working Group.

Considering the stabilizing health situation, high density of health facilities, and approach for rationalising health service, the Health Sector aims to move away from mobile health teams and towards promoting **facility-based health services**. Various **means of transport** exist to ensure that immobile patients can reach health facilities. CHWs are an essential part of this system in arranging **porters** through health facilities to bring patients to the services. **Attending patients at home** by health care workers is available as a last resource. UNHCR is planning to further strengthen the patient referral from the home to the facility by making systematic use of existing volunteer networks in areas not reachable by other transport means.

Additionally, as part of Emergency Preparedness and Response planning for natural hazards and to ensure availability of health services, **6** nutrition mobile teams have been established; Mobile medical teams formed in all supported health facilities, **2,080** refugee volunteer CHWs and Nutrition Workers have been trained on emergency first aid; and **350** community volunteers and counsellors have been trained on psychological first aid, counselling, and mental health referrals. As noted above, refugee **CHWs** are also engaged in identifying, referring, and transporting refugees with physical mobility challenges to health services.

Part IV: Addressing Existing Gaps and Challenges

UNHCR acknowledges that gaps remain in regard to:

- **Space constraints and adequate resources** required to address the challenges of older persons in site planning and construction of facilities and community spaces;
- Better **understanding positive roles older persons play in the community**, capitalising on their experiences and tailoring programmes to build cohesion between refugees of all ages and abilities;
- **Tapping into existing capacity and experience of national actors** working with persons with disabilities and older persons, to promote sustainability - although some capacity building is required given the limited experience working in refugee contexts; and
- **Developing communication materials** which respond to specific challenges of older persons with sight and hearing impairment.

Thus, to improve service coverage, ensure targeted support for those in need, and improve access to services and meaningful participation in camp life, UNHCR and its partners are currently focussing on:

- Enhancing **profiling** of refugee disabilities, associated vulnerabilities, community support, and coping mechanisms to complement data collected in the Registration exercise and camp profiles;
- Comprehensive **mapping of services** for older persons and persons with disabilities to better understand gaps and facilitate efficient utilisation of all available resources;
- Strengthening **referrals and holistic interventions** through multisector outreach (Protection, MHPSS, and Health) to identify persons/families in need of assistance, offer psychological first aid and community solutions where possible, while referring serious cases for case management;
- Inclusive **community-based support** and solutions through **mainstreaming AGD** in programmes (disabled/elderly friendly infrastructure and community spaces to promote participation), supporting disabilities and elderly self-help groups, and encouraging **inclusivity** through inter-generational social and recreational activities.

ANNEX II: IOM RESPONSE

International Organization of Migration (IOM)
Dhaka - Bangladesh

Reference: TIGO IOR 30/2019.001

30 May 2019

Dear Mr. Matthew Wells
Senior Crisis Advisor
Crisis Response Programme
Amnesty International

IOM Bangladesh would like to present its compliments to your organization and appreciate the opportunity given to contribute to your report. Please see following our comments to the questions your office addressed to us. We remain available to provide at any time any other clarification and we will be available to meet in the future any mission you may have to Cox Bazar

Part I: Population Data

- How does IOM define an “older person” in the context of the refugee response in Bangladesh?
 - For IOM an older or elderly person is defined as 60 years old or more¹
- As part of its operations, does IOM systematically collect, analyse, and disseminate age-disaggregated data?
 - Yes, age disaggregation is an important feature of IOM distribution planning, activities monitoring and services analysis. To note that IOM doesn’t implement registration and depends on the Government of Bangladesh and UNHCR since they are the custodians of the registration activities for refugees in country.
 - Furthermore, IOM Needs and Population Monitoring Unit collects data primarily through Key Informants Methodology. This involves asking a community leader to describe the needs and perceptions of households that fall within a block or boundary for which he/she is responsible for and doesn’t allow age disaggregation. The age disaggregated data would normally be best captured through a household level sampling approach such as the one that UNHCR collects through registration exercises (although this would also have limitations). Matching KI data with factual age desegregation will be possible when refugee registration is completed later this year, until now its extrapolated from UNHCR family counting data.
 - The vulnerability data that IOM collects is available on request. It is not publicly disseminated as NPM is aware of the inherent limitations associated with Key Informant Methodology. There are more appropriate methodologies being used by other actors to collect the specific data that is mentioned.
 - NPM collects information at the “location/block level” (approximately 2,000 locations every 2 months). We ask Key Informants: “What is the current number of people with disabilities in this location?” (This includes genetic or intellectual (Down Syndrome, Autism), mental health conditions (anxiety, depression, bipolar schizophrenia), physical and sensorial impairment (hearing, visual, physical, speech).
- If so, how, specifically, does IOM disaggregate data based on age (i.e., what specific age brackets are used)?
 - Since IOM doesn’t implement registration and data collection is associated with service delivery on an individual basis age brackets may vary on reporting depending on donor requirements, but the conventional brackets are – child <18, youth 15-24, adult 18-59 and older person >60.
 - NPM assessments also include the following specific questions:
 - What is the current number of families that are headed by someone over 60 in this location?
 - What is the current number of child (under 18) headed families in this location?
 - What is the current number of unaccompanied children under the age of 18 in this location?
- As part of its operations, does IOM collect, analyse, and disseminate disaggregated data associated with vulnerability factors other than disability? If so, on which factors and how?
 - IOM through its health and protection programs in the areas of responsibility provides specialized services to those individuals and referrals to other specific agencies. Case management or medical data is not made available public.

¹ IOM follows the UN definition - 60 years and over as a cutoff age for “elderly” or “older person” to extend the eligibility criteria for ageing-related development projects (UN, 2001 in WHO, 2002) more at <https://migrationdataportal.org/themes/older-persons-and-migration>

- Nonetheless NPM further collects aggregated information at the location/block level on:
 - What is the current number of female headed families in this location?
 - What is the current number of families that are headed by someone over 60 in this location?
 - What is the current number of child (under 18) headed families in this location?
 - What is the current number of unaccompanied children under the age of 18 in this location?
 - What is the current number of pregnant or lactating women in this location?
 - What is the current number of people with disabilities in this location?
- How many older persons are living alone among the refugee population in the camps?
 - NPM does not collect this type of information however UNHCRs family counting has 787 older persons at risk were identified as living alone.
- How many vulnerable persons are living alone among the refugee population in the camps, including older persons with vulnerabilities?
 - NPM does not collect this type of information however UNHCRs family counting has 2,973 individuals with some vulnerability were identified as living alone
- How many older persons in the camps are acting as primary caregivers (for example, though not limited to, older people caring for grandchildren whose parents were killed during the military operations)?
 - NPM does not collect this type of information however UNHCRs family counting has 4,647 families were identified as older persons at risk with children.
- How many vulnerable persons in the camps are acting as primary caregivers, including older persons with vulnerabilities?
 - NPM does not collect this type of information however UNHCR and the Government of Bangladesh's ongoing registration exercise will have this number when completed. IOM through its protection programs in the areas of responsibility provides specialized services to some of those individuals and referrals to other specific agencies. Case management data is not made available.

Part II: Community Consultation

- How has IOM consulted with older Rohingya women and men as part of the humanitarian response? In what ways, if any, does IOM think the humanitarian response could improve in its consultation and active involvement of older refugees?
 - IOM continues to consult regularly with refugee groups to maintain programing proactive and attentive to refugee needs, we also promote regular post distribution/service monitoring to incorporate feedback on further planning throughout the response through different programs and means:
 - Focus Group Discussion;
 - Key Informant Interviews;
 - Outreach (household door to door visit specially for shelter bound individuals) since refugees prefer face to face interaction
 - And throughout IOM programing at large (within facilities such as health posts, mental health desks, feedback and complaint desks, Site Management Offices, protection monitoring, Women and Girl Friendly Spaces activities, Para development committees, etc.)
 - Specifically, IOM has consulted with both older Rohingya women and men as well as Rohingya women and men with vulnerabilities to define specific needs, referrals to services and protection concerns and solutions within our normal sectorial programing. We believe more can be done by IOM to consult and protect refugees with disabilities or and elderly, in particular in what concerns their physical location, unfortunately the lack of space in camps and the reluctance of the concerned individuals and their families to relocate continues to pose challenges to such that IOM will continue to work on.
- How has IOM consulted with Rohingya women and men with vulnerabilities? In what ways, if any, does IOM think the humanitarian response could improve in its consultation and active involvement of refugees with vulnerabilities, including older refugees with vulnerabilities?
 - In terms of a way forward, the humanitarian response could improve by being more systematic and coordinated in the above-mentioned consultations within the Protection Sector. An inter-agency data exchange and access when the GoB/UNHCR registration is completed can help better define in a systematic and comprehensive way

specific programming regarding elderly members of the Rohingya communities as well as people living with disabilities can be implemented; since its important to reduce current fatigue from the communities caused by regular unilateral consultations conducted by organizations. In addition, better integration of members/representatives of those two groups to existing and / or planned community representation structures will be key to ensure a meaningful and consistent consultation of elderly persons and persons living with disabilities.

- One way of improving should also be a stronger effort in producing more specific communication materials and services for individuals with impairments such as audio messages, dedicated guides in facilities, priority lanes or dedicated timing for services.
- A lot of attention as been put on engaging youth groups but very limited resources have so far reduced opportunities to redirect similar efforts to elderly individuals, IOM is developing a project called Historical Memory Center that will be able to tap and valorize the role of volunteer elderly individuals as the custodian of tradition, identity and culture. The center will contribute to intergenerational leaning and sharing.
- When IOM needs to communicate a change in assistance to refugees, or needs to otherwise get information disseminated to the refugee population, what is its standard practice for doing so?
 - The CiC and partners are informed during the weekly / bi-weekly camp coordination meetings;
 - The information is passed through the various community representation structures (which varies between the camps) such as community volunteers, elected representatives, Magiies, imams, elder councils, etc
 - The information is also directly disseminated by several means within the SM and CwC teams via:
 - Information desks,
 - Radio listening groups,
 - Door -to door outreach
 - Town halls meetings,
 - Visuals at key locations (distribution sites, etc.)
 - The Complaints & Feedback Mechanism (CFM) also allows for people to raise complaints for example when they believe have not received the adequate assistance. Refugees prefer face to face interaction and IOM and partners have establish 59 CFM across camps.

Part III: Accessibility – Physical Infrastructure

- What factors have gone into deciding where to construct new latrines? What specific attention has been paid to older age, vulnerability, and disability in selecting locations for latrines—in particular to maximize access?
 - Due to the short timeframe and high demand for WASH services during the initial influx, the WASH unit was not able to meet the requirements of any specific groups' needs. Throughout the emergency period, the unit assessed WASH needs based on the total population in each camps; and attempting to create an equitable coverage for all refugees. Each latrine cubicle was designed for maximum of 20 people. Following the WASH sector guidelines, latrines were installed to a maximum 50 meters from the households and 10 meters away from the water sources. As the response started stabilizing and humanitarians started transitioning towards a stable state from the emergency, IOM started to construct twin pit latrines or upgraded emergency latrines to semi-permanent gender segregated twin pit latrines to ensure equal access of men and women. However, at present, the WASH sector is working with Site Management and Development to select locations for the installation of new latrines- which continues to be a challenge due to limited space and congestion. The WASH sector is preparing a comprehensive roadmap in collaboration with agencies working to provide WASH services to ensure inclusion of gender and GBV aspects in WASH interventions. Specific needs and vulnerabilities are planned to be addressed by retrofitted selected facilities, identified for individuals that will remain in their current location but considering the geography of the camps efforts are under way to support some relocations to mitigate accessibility challenges. IOM is partnering with Cristina Blind Mission and Handicap International for pilot projects and advocating for home based solution at least to the most critical cases .
- What limitations are there, for example as a result of the camp terrain and other environmental factors, when determining feasible locations for latrines?
 - High density in the camps have often been a limiting factor while choosing an appropriate location for the installation of latrines. In addition to the high density, many sites can't be used as they are highly vulnerable to landslide or flooding. This further reduces the amount of land available for new installation from already limited amount of available space. Removal of sludge solutions constitutes also significant challenges on this process.

- **What plans exist for improving lighting in the camps, particularly on pathways around latrines?**
 - In 2018 the Site Management Sector conducted an initial large scale mapping of all lighting needs last years. The plan included installing light near pathways, facilities and near latrines. Last year IOM installed 2200 solar lights including near latrines with the support of DFID and PRM.
 - In 2019 the ADB will be installing additional solar lights. The prioritization of the locations to be targeted by solar street lights was made in consultation with communities and the Site Management Sector and agencies.
 - IOM shelter/NFI program has also distributed until this month more than 57,509 solar lamps to refugee families covering 53% of the overall population under IOM camp management, other IOM partners have distributed 104,702 units in the remaining areas raising the overall coverage to 148%; we now considered that majority of families have at least one unit. The creation of mini-grid systems is also being studied for community infrastructures and social spaces.
- **In constructing new shelters and moving people to new shelter locations, what consideration is given to the rights and needs of older people? What consideration is given to various vulnerability factors?**
 - When providing shelter support IOM collects case data beforehand of all households, allowing to identify different vulnerabilities and correspondent needs - elderly, disabled, pregnant and lactating etc. These extreme vulnerable individuals (EVI) receive dedicated logistical support to transport materials and personal items or individuals from the distribution point or previous location and receive IOM technical/labor support to perform the actual upgrade of their shelter in new location. New plot assignment location is also factored in the specific needs assessment of these individuals.
 - Furthermore, IOM has relocated PWD identified as EVI in need of relocation for disaster preparedness and response, and SMSD through partners has been doing home rehabilitation and upgrades. IOM's implementing partners that specialize in PWD support are in select camps providing services and referrals. IOM's goal is to increase the inclusiveness of PWDs across all sectors and services in the camps it manages.
- **What programs, if any, exist for helping people with limited or no mobility, including older people with limited or no mobility, in accessing food distributions and adequate drinking water?**
 - IOM doesn't provide food services, but the concerns applies to service provision such as shelter/NFI or LPG in these locations vulnerable individuals are 'fast tracked' for distribution, so they are served first before IOM porters take the relief items to their shelter location across the camps
 - Recently the distribution point in camp 18 was upgraded to be leveled and include a ramp to allow for easier access for elderly and people with disabilities. IOM is also proceeding with an exercise to analyze all its facilities to ensure the inclusion of adequate access and fruition by vulnerable individuals. Upgrades on access structures, waiting areas, latrines and breastfeeding points are the priorities to be implemented with this exercise

Part III: Accessibility – Health Services

- **What minimum standards exist for clinics and other health facilities operating in the camps, and when were these standards adopted? In particular, what minimum standards exist around the stocking of medication for chronic conditions like high blood pressure, diabetes, and chronic respiratory illness like asthma?**
 - In response to the health needs resulting from the influx in mid-2017, IOM is providing Emergency Primary Health Care services that includes; General services, Child Health, Maternal Health, Communicable diseases and Non-Communicable diseases such as Hypertension, Diabetes, Asthma, Chronic Obstructive airway Diseases, Mental Health and Psychosocial Support Services.
 - The medical commodities (supplies, medicines and equipment) are obtained through predominantly IOM procurement systems based on needs and items described in the national and WHO Essential Drug List. Other supplies such as the Interagency Emergency Health Kit and Sexual Reproductive Health kits is readily supplied by WHO and UNFPA respectively. IOM has established medical warehouse that meet recommended storage conditions in the immediate environ of the Refugee camp to facilitate timely replenishment to the health facilities. Under these circumstances, there hasn't been any rupture in the supply chain-no stock out reported
- **What referral system and standards exist within the camp medical response? For example, if one camp clinic is unable to diagnose or treat a person, including through providing appropriate medication, what is the protocol for referring that person to another camp clinic that could diagnose and treat the person? If a person with limited or no mobility needs to be referred, what is the protocol for ensuring that person can access the appropriate clinic?**
 - The medical system operates in cooperation with GoB DH under a referral protocol that allows patients to be referred between facilities when specific services and not available, the mechanism operates from camps to

Chitagong. IOM currently offers a fleet of 12 ambulances operated through a 24/7 dispatch call center, we provide and cost referral services that move patients out of the camps for diagnostic and treatment services in the most adequate location. IOM facilitates referrals out of the refugee camps in Ukiah and Teknaf to Cox's Bazar district hospital and Chittagong - the provincial hospital for specialized medical services. In addition to transportation, IOM referral services covers for treatment/diagnostic costs, feeding for care givers and patients, transportation back to the camps. Since the influx, IOM has conducted over 11,000 referrals.

- Overcrowding and complex physical terrain presents a continuous challenge for movement of people with limited or no mobility or critical ill from their households that can't be accessed by vehicle ambulances. Different targeted approaches are being applied at community level such as; use of tri-cycle automobiles-'tom-tom' use of stretchers by family members or volunteers to bring such patients to a point that the ambulance can take over. Considering these limitations and the recurrent challenges of the operation we still see as positive that the overall coverage of health facilities in most camps has been describe as adequate except for isolated cases e.g. Camp 26 (Health Sector/GoB)
- What challenges exist in improving the referral system to Bangladesh hospitals, when camp clinics are unable to provide adequate medical care? In particular, what steps are being taken to ensure that people in need of medical care outside the camps are able to access that care?
 - Under the auspice of the health sector, IOM and UNCHR are the two lead agencies managing the bulk of all referrals out of the service providers using the mechanism described above. Under this SOP, the referral mandate is aligned to camp management responsibilities. IOM is responsible to support all health partners in its area of responsibility and facilitates onward patient referral whenever needed.
 - Generally, movement of refugees in/out of the camps is controlled by the local camp administrators - CIC. Although acute medical emergencies are waived of this prior permission, this is not the universal norm. There are frequent instances where lifesaving referrals are delayed because of the need for approval.
- What plans exist for making the medical response more mobile, including through providing assistance, where necessary, in people's shelters (e.g., for people with limited mobility or who are shelter-bound)?
 - As the population becomes more settled, IOM has established and is supporting static health facilities while ensuring that the facilities are within 30mins reach for more than 80% of the users in the catchment area of those facilities. This approach also allowed IOM to continue to provide more comprehensive and specific services such as Inpatient care, laboratory services, ultrasound services, delivery services-all of which improved the quality of care and reduced referral needs; that would have not been possible with Mobile Response Teams approach. Nonetheless IOM sees that the MRTs play a key role on expanding coverage and reaching specific needs, so options are being evaluated to consider the possibility of having some of such teams associated with the static units as a complement and in conjunction with the outreach community health workers that already exist across the camps. Also under the current preparedness plans mobile response team are envisioned to integrated into static clinics to readily be available for deploy when needed in outbreak, new influx, damaged facilities, etc. A network of 350 Community Health Workers are deployed at community level and go house-to-house conducting health promotion. During this process they help identify shelter bound individuals in need of medical services and coordinate with nearby health facility for assistance

Yours sincerely on behalf of the IOM Chief of Mission,



Manuel Pereira
IOM Deputy Chief of Mission

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“FLEEING MY WHOLE LIFE”

OLDER PEOPLE’S EXPERIENCE OF CONFLICT AND DISPLACEMENT IN MYANMAR

As the Myanmar military has carried out atrocity-marred operations in recent years, older women and men from ethnic minorities have often been at particular risk of being killed or ill-treated, linked to their staying or being left behind in villages. Tens of thousands of other older people have fled their homes and villages to displacement settings, where their risks and hardships are frequently overlooked, further undermining their basic rights. For many, it is the latest chapter in a lifetime of displacement and military abuse.

This report is based primarily on 146 interviews with older women and men during research missions to northern Myanmar, to Rakhine State, and to the refugee camps in Bangladesh. It examines older people’s experience of conflict and oppression in Myanmar—both particular violations and the cumulative psychosocial impact. The report also analyses how and why humanitarian assistance has failed to meet many older people’s rights and needs, including related to health, sanitation, food, water, and participation.

Accountability for the Myanmar military’s atrocities should include a focus on the specific crimes committed against older women and men, and draw on older people’s unique communal knowledge and memory. For their part, donor governments, UN agencies, and humanitarian organizations must better ensure that assistance is inclusive, non-discriminatory, and respects older people’s rights, including to dignity.