



**NGO Statement Concerning Sexual and Reproductive Rights of
Rohingya Women and Girls Displaced Due to Conflict
in advance of the UN Security Council's Mission to Myanmar, Bangladesh**

April 26, 2018

Overview

Almost 750,000 Rohingya refugees have crossed the border into Cox's Bazar, Bangladesh in the wake of violence and widespread human rights abuses in Myanmar's Rakhine state starting in October 2016, the vast majority arriving since the latest round of violence began in August 2017.¹ Approximately 60% of new arrivals are women and girls.² Estimates suggest that around twenty-four thousand pregnant and lactating Rohingya women require maternal health-care support in health-care facilities.³ Displaced Rohingya women have faced inadequate access to crucial sexual and reproductive health services.⁴ Life-saving emergency obstetric care is not available 24/7 for a majority of residents and access to transportation to health facilities is limited.⁵ As a result, Rohingya women are at acute risk of maternal mortalities and morbidities. Access to voluntary contraception in refugee camps is limited as few health facilities are fully equipped to provide a full range of contraceptives.⁶ Policy barriers also prevent health personnel from providing a complete range of contraceptives.⁷ Abortion is illegal in Bangladesh except where undertaken to save the life of a pregnant woman⁸; however, the law does provide for "menstrual regulation," which can be performed

¹ Michael Safi, "UN chief and rights groups raise concerns over Rohingya deal," THE GUARDIAN, Jan. 17, 2018, <https://www.theguardian.com/world/2018/jan/17/un-chief-and-rights-groups-raise-concerns-over-myanmar-rohingya-deal>; UN WOMEN, GENDER BRIEF ON ROHINGYA REFUGEE CRISIS RESPONSE IN BANGLADESH I (2018) available at <http://www2.unwomen.org/-/media/field%20office%20eseasia/docs/publications/2017/10/gender-advocacy-paper-for-rohingya-refugee-crisis-response-in-bangladesh-r10.pdf?la=en&vs=2521>.

² INTER AGENCY WORKING GROUP (IAWG), WOMEN AND GIRLS CRITICALLY UNDERSERVED IN ROHINGYA REFUGEE RESPONSE (Feb. 22, 2018), available at <https://reliefweb.int/sites/reliefweb.int/files/resources/IAWG%20Statement%20on%20Rohingya%20Humanitarian%20Response.pdf> [hereinafter IAWG, ROHINGYA REFUGEE RESPONSE].

³ UN WOMEN, GENDER BRIEF ON ROHINGYA REFUGEE CRISIS RESPONSE IN BANGLADESH, *supra* note 1, at 2.

⁴ IAWG, ROHINGYA REFUGEE RESPONSE, *supra* note 2.

⁵ INTER SECTOR COORDINATION GROUP AND WORLD HEALTH ORGANIZATION, ROHINGYA REFUGEES IN BANGLADESH: HEALTH SECTOR BULLETIN NO. 1 (Oct. 1 – Nov. 15, 2017), available at <https://reliefweb.int/report/bangladesh/rohingya-refugees-bangladesh-health-sector-bulletin-no1-period-01-october-15>.

⁶ IAWG, ROHINGYA REFUGEE RESPONSE, *supra* note 2.

⁷ *Id.*

⁸ Penal Code No. 45 of 1860, secs. 312-316 (1860) (Bangl.).

within twelve weeks⁹ of a woman's last menstruation without confirmation of pregnancy.¹⁰ Unfortunately, even menstrual regulation services are available in only ten facilities throughout the camp.¹¹

The need for sexual and reproductive health services is particularly acute given the widespread threat and use of sexual violence against women and girls in Rakhine state as part of the campaign of ethnic cleansing undertaken by the Myanmar Armed Forces from October 2016 and August 2017, as recognized by the Secretary General in his recent report on conflict-related sexual violence.¹² These attacks follow in a pattern of the use of sexual violence against Rohingya women.¹³ While it is difficult to estimate the number of rapes that have occurred, humanitarian agencies in Bangladesh refugee camps report receiving dozens and sometimes hundreds of cases.¹⁴ Humanitarian organizations have reported providing services to 2,756 survivors of sexual and gender-based violence (SGBV), though this figure is likely low due to stigma and other barriers to reporting SGBV.¹⁵ Many of these rapes have resulted in pregnancies.

However, post-rape care, which includes emergency contraception, safe abortion and counseling service remains inadequate in the refugee camps,¹⁶ with 47 per cent of settlement areas still lacking basic clinical management services for survivors of rape and other forms of sexual and reproductive health care.¹⁷ Many of the women and girls raped by the Myanmar Armed Forces in mid-2017 are due to give birth in the next few weeks, and there are concerns that many women will not be able to access medical care to give birth safely; even where there are hospital facilities they are often not accessible.¹⁸ These women and girls urgently require access to sexual and reproductive health and psychological services.¹⁹

Even after arriving in refugee camps in Bangladesh, women and girls remain at risk for gender-based violence, including child, early, and forced marriage and trafficking.²⁰ Overcrowded camps and limited privacy increase security risks for women and girls.²¹ Moreover, some Rohingya families have forced girls as young as 11 to marry in hopes of securing more food

⁹ Bangladesh Family Planning Department, Ministry of Health, National Guidelines on Menstrual Regulation (2013).

¹⁰ Susheela Singh *et al.*, *The Incidence of Menstrual Regulation Procedures and Abortion in Bangladesh* 38(3) INTERNATIONAL PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH, 122, 122 (2012).

¹¹ IAWG, ROHINGYA REFUGEE RESPONSE, *supra* note 2.

¹² U.N. S.C. Rep. of the Secretary General on Conflict-Related Sexual Violence, para. 55, U.N. Doc. S/2018/250 (23 Mar 2018) [hereinafter U.N. S.C. Rep. of the SG on Conflict-Related Sexual Violence 2018].

¹³ HUMAN RIGHTS WATCH (HRW), "ALL OF MY BODY WAS PAIN": SEXUAL VIOLENCE AGAINST ROHINGYA WOMEN AND GIRLS IN BURMA (2017), available at <https://www.hrw.org/report/2017/11/16/all-my-body-was-pain/sexual-violence-against-rohingya-women-and-girls-burma> [hereinafter HRW, SEXUAL VIOLENCE AGAINST ROHINGYA WOMEN AND GIRLS].

¹⁴ *Id.*

¹⁵ U.N. S.C. Rep. of the SG on Conflict-Related Sexual Violence 2018, *supra* note 12, para. 55.

¹⁶ IAWG, ROHINGYA REFUGEE RESPONSE, *supra* note 2; see also [HRW, SEXUAL VIOLENCE AGAINST ROHINGYA WOMEN AND GIRLS, *supra* note 13.](#)

¹⁷ U.N. S.C. Rep. of the SG on Conflict-Related Sexual Violence 2018, *supra* note 12, at 55.

¹⁸ IAWG, ROHINGYA REFUGEE RESPONSE, *supra* note 2.

¹⁹ [HRW, SEXUAL VIOLENCE AGAINST ROHINGYA WOMEN AND GIRLS, *supra* note 13.](#)

²⁰ *As Rohingya Refugee Crisis Escalates, Women Emerge as Front-line Responders*, UNFPA, Dec. 6, 2017, <https://www.unfpa.org/news/rohingya-refugee-crisis-escalates-women-emerge-front-line-responders>.

²¹ *Id.*

for themselves and the rest of their families.²² Other Rohingya girls are being sold to much older men in places such as India.²³

Sexual and Reproductive Health and Rights of Rohingya Women Under International Law

The rights of Rohingya women and girls are protected by multiple and complementary bodies of international law, including international human rights law (IHRL), international humanitarian law (IHL), international criminal law, and refugee law. International legal and political bodies have affirmed that fundamental human rights obligations, including sexual and reproductive health and rights (SRHR), continue to apply even during situations of armed conflict.²⁴ In addition to human rights treaty bodies, the UN Security Council has passed several resolutions in the past 15 years relating Women, Peace, and Security that touch on SRHR and has urged “United Nations entities and donors to provide non-discriminatory and comprehensive health services, including sexual and reproductive health” to survivors of sexual violence.²⁵ In addition to specific references to SRHR, these resolutions affirm the applicability of states’ human rights obligations in situations of armed conflict.²⁶

With the prevalence of sexual violence in conflict, human rights bodies increasingly have provided recommendations regarding gender-based violence experienced by women and girls, particularly with regard to access to contraception and safe abortion care for survivors.²⁷ In its general recommendation on women in conflict, the CEDAW Committee urges states to prevent, investigate, and punish all forms of SGBV, particularly sexual violence committed both by state and non-state actors, and to ensure survivors’ access to justice, comprehensive medical treatment, and psychosocial support.²⁸ The UN Secretary General has called for humanitarian responses to include access to safe abortion care and emergency contraception for pregnancies resulting from rape,²⁹ and the UN Security Council has recognized the importance of including “access to the full range of sexual and reproductive health services” for women and girls affected by conflict, “including regarding pregnancies resulting from

²² See *id.*; Ann Taylor, *Child Marriage in the Rohingya Camps in Bangladesh*, THE ATLANTIC (Dec. 14, 2017).

²³ Roli Srivastava, *Lured with a happily-ever-after dream, Rohingya girls sold in India*, REUTERS, Jan. 22, 2018, <https://www.reuters.com/article/us-india-trafficking-rohingya/lured-with-a-happily-ever-after-dream-rohingya-girls-sold-in-india-idUSKBN1FB1LD>.

²⁴ See *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, 2004 I.C.J., para. 136 (July 9); *Legality of the Threat or Use of Nuclear Weapons*, Advisory Opinion, 1996 I.C.J., para. 25 (July 8); S.C. Res. 2122, preamble, U.N. Doc. S/RES/2122 (Oct. 18, 2013); S.C. Res. 1325, para. 9, U.N. Doc. S/RES/1325 (Oct. 31, 2000).

²⁵ S.C. Res. 2106, para. 19, U.N. Doc. S/RES/2106 (June 24, 2013).

²⁶ *Id.*; S.C. Res. 2122, preamble.

²⁷ See CEDAW Committee, *General Recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations*, para. 52(c), U.N. Doc. CEDAW/C/GC/30 (2013) [hereinafter CEDAW Committee, *Gen. Recommendation No. 30*]; CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, paras. 10, 32, U.N. Doc. CEDAW/C/COD/CO/6-7 (2013); see also CEDAW Committee, *Concluding Observations: Central African Republic*, paras 39-40, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014) (recommending that the state “[e]nsure that women who are victims of rape, including rapes perpetrated during the conflict, have access to health-care and psychosocial services, including emergency contraception and safe abortion services”); CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, paras. 35-36, U.N. Doc. CEDAW/C/COD/CO/5 (2006) (calling on the state to “improve the availability of sexual and reproductive health services, including family planning, also with the aim of preventing early pregnancies and clandestine abortions”).

²⁸ CEDAW Committee, *Gen. Recommendation No. 30*, *supra* note 27, para. 38(e); see also CAT Committee, *Concluding Observations: Iraq*, para. 13, U.N. Doc. CAT/C/IRQ/CO/1 (2015).

²⁹ U.N. Secretary General, *Sexual Violence in Conflict: Rep. of the Secretary-General*, para. 12, U.N. Doc. A/67/792-S/2013/149 (Mar. 14, 2013).

rape” as part of humanitarian aid and funding.³⁰ The CEDAW Committee also calls on states to safeguard refugees and internally displaced persons from SGBV, including child and forced marriage, and to provide them with immediate access to medical services and to create accountability mechanisms for SGBV in all displacement settings.³¹

Human rights treaty bodies have found that the denial of safe abortion care to survivors of rape in armed conflict violates the rights to health and privacy and could amount to a violation of the prohibition on ill-treatment.³² Non-derogable minimum core obligations related to sexual and reproductive health require states to take steps to prevent unsafe abortion and to provide post-abortion care and counseling; they also require states to “repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine individual’s or particular group’s access to sexual and reproductive health facilities, services, goods and information.”³³

In conflict-affected settings, the CEDAW Committee has explicitly called on states to ensure access to “maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care . . . complications of delivery or other reproductive health complications, among others.”³⁴ The Committee has interpreted the Convention to require “women seeking asylum and women refugees be granted, without discrimination, the right to . . . health care and other support, . . . appropriate to their particular needs as women.”³⁵ In its recommendations to specific states, the CEDAW Committee has noted with concern the effects of armed conflict on SRHR and maternal mortality, in particular, calling on states affected by conflict to “accord priority to the provision of sexual and reproductive health services.”³⁶ CESCR considers the obligation to ensure reproductive and maternal health care to be comparable to a minimum core obligation with which states must comply at all times.³⁷

Violations of rights require a remedy. A broad and robust understanding of accountability is necessary to ensure that perpetrators of specific abuses as well as others who have an impact

³⁰ S.C. Res. 2122, preamble.

³¹ CEDAW Committee, *Gen. Recommendation No. 30*, *supra* note 27, para. 57.

³² *Id.*, para. 52(c); CEDAW Committee, *Concluding Observations: Syria*, para. 40, U.N. Doc. CEDAW/C/SYR/CO/2 (2014); CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, para. 32(e), U.N. Doc. CEDAW/C/COD/CO/6-7 (2013); Human Rights Committee, *Concluding Observations: Democratic Republic of the Congo*, paras. 13-14, U.N. Doc. CCPR/C/COD/CO/3 (2006).

³³ CESCR, *General Comment No. 22 (2016) on the Right to sexual and reproductive health*, para. 49, U.N. Doc. E/C.12/GC/22 (2016).

³⁴ See CEDAW Committee, *Gen. Recommendation No. 30*, *supra* note 27, para. 52(c).

³⁵ CEDAW Committee, *General Recommendation No. 32 on the gender-related dimensions of refugee status, asylum, nationality and statelessness of women*, paras. 33-34, U.N. Doc. CEDAW/C/GC/32 (2014).

³⁶ CEDAW Committee, *Concluding Observations: Central African Republic*, para. 40(b), U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014); see also CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, paras. 35-36, U.N. Doc. CEDAW/C/COD/CO/5 (2006) (noting concern “about the highly negative impact on maternal and infant mortality and morbidity rates of the protracted armed conflict, which resulted in lack of access to obstetric care, dilapidated clinics and lack of utilization of existing services during pregnancy and childbirth” and recommending the state take steps to improve women’s access to emergency obstetric care and health-related services, in particular).

³⁷ CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, para. 43, contained in U.N. Doc. E/C.12/2000/4 (2000); CESCR, *General Comment No. 3: The Nature of States Parties’ Obligations (Art. 2, Para. 1, of the Covenant)*, para. 10, contained in U.N. Doc. E/1991/23 (1990). See also Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, para. 11, U.N. Doc. A/68/297 (Aug. 9, 2013) (by Anand Grover) [hereinafter SR Health Report 2013].

on affected individuals and communities are held responsible for their actions and decisions. Effective accountability mechanisms require participation and transparency as well as the ability to confer meaningful and effective remedies to victims of violations on a basis of non-discrimination.³⁸ International human rights and political bodies have recognized that accountability requires prompt investigation into violations and punishment of perpetrators as well as legal and policy shifts in order to prevent future violations.³⁹ Remedies, moreover, must aim to restore the rights of victims of violations and must include adequate, effective, and prompt reparation, forms of which include restitution, compensation, rehabilitation (e.g. medical or psychological services), satisfaction, and guarantees of non-repetition.⁴⁰

Sexual and Reproductive Health Services Must Be Scaled Up to Protect and Fulfill the Rights of Rohingya Women and Girls

Treaty monitoring bodies have expressed concern regarding grave risks to sexual and reproductive health faced by Rohingya women and girls. The Committee on Economic Social and Cultural Rights, in its Concluding Observations on the initial report of Bangladesh, noted the lack of access for Rohingya refugees to “healthcare services, education and other basic services” outside refugee camps due to the absence of legal status.⁴¹ The Human Rights Committee expressed concern that Rohingya women and girls are exposed to “sexual and gender-based violence and domestic violence” in refugee camps in Bangladesh.⁴²

In its report on the upcoming Universal Periodic Review of Bangladesh at Human Rights Council, OHCHR has noted that the United Nations High Commissioner for Refugees (UNHCR) was concerned about “increasing gender-based violence against unregistered Rohingya women and girls” and recommended that Bangladesh ensure that all refugee and stateless women and girls have “effective access to justice.”⁴³ The stakeholders’ submissions for the upcoming Universal Periodic Review also expressed concern regarding “limited access to health for many Rohingya women and girls living with HIV/AIDS.”⁴⁴

³⁸ See generally G.A. Res. 60/147, *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*, A/RES/60/147 (21 March 2006) [hereinafter G.A. Res. 60/147]; see also SR Health Report 2013, *supra* note 37, paras. 61-67.

³⁹ G.A. Res. 60/147, *supra* note 38, para. 3(b).

⁴⁰ Restitution aims to restore the victim to her original situation before the violation and includes restoration of enjoyment of human rights, return to one’s place of residence, or return of property. Compensation is required as appropriate and proportional to the gravity of the violation and the circumstances of each case. Rehabilitation includes medical and psychological care as well as legal and social services. Satisfaction aims to ensure the cessation of continuing violations and includes verification and public disclosure of facts. Guarantees of non-repetition aim to prevent future violations and include structural and systemic changes, such as legal reform and education. *Id.* paras. 19-23. See also Human Rights Committee, General Comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant, para. 16, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004); CAT Committee, *General Comment No. 3: Implementation of article 14 by States parties*, para. 2, U.N. Doc. CAT/C/GC/3 (2012); CEDAW Committee, *General Recommendation No. 33 on women’s access to justice*, para. 19(f), U.N. Doc. CEDAW/C/GC/33 (2015).

⁴¹ Committee on Economic Social and Cultural Rights, *Concluding Observations On Initial Report of Bangladesh*, para. 27 U.N. Doc. E/C.12/BDG/CO/R.1 (2018).

⁴² Human Rights Committee, *Concluding Observations On Initial Report Of Bangladesh*, para. 17, U.N. Doc. CCPR/C/BGD/CO/1 (2017).

⁴³ Office of High Commissioner on Human Rights, *Report on Bangladesh for thirtieth session of Human Rights Council*, para 70, U.N. Doc. A/HRC/WG.6/30/3GD/2 (2018).

⁴⁴ Office of High Commissioner on Human Rights, *Summary of Stakeholders’ Submission on Bangladesh for thirtieth session of Human Rights Council*, para. 54, U.N. Doc. A/HRC/WG.6/30/BGD/3 (2018).

A Statement by the President of the Security Council from November 2017 called for the implementation of Resolution 2106, stressing the importance of transparent investigations and effective accountability mechanisms into allegations of sexual violence.⁴⁵ The statement urged “the Governments of Myanmar and Bangladesh, the United Nations, and other humanitarian partners to pay special attention to the specific needs of women and girls in all assessments, planning and delivery of humanitarian assistance and to ensure the availability of specialised medical and psychosocial services for survivors of sexual violence.”⁴⁶

These violations are exacerbated by and in turn reinforce gender-based inequalities and patterns of gender-based violence, further diminishing the capacity of women and girls to enjoy fundamental human rights, including sexual and reproductive rights. Access to sexual and reproductive health information and services is fundamental to an adequate humanitarian response to this crisis and to ensuring the rights of Rohingya women and girls under international law.

The lack of crucial sexual and reproductive health services entails widespread violations of the sexual and reproductive rights of Rohingya women displaced as a result of conflict. The Government of Bangladesh, relevant UN agencies, and humanitarian organizations should work together to:

- Ensure the availability of sexual and reproductive health services including obstetric, prenatal, and post-natal care; contraceptive information and services, including emergency contraception; and safe abortion services and menstrual regulation, including for victims of rape and sexual violence and married girls.
- Ensure participation of Rohingya women and girls in the process of development and implementation of programs, including sexual and reproductive health services, and set up clear monitoring mechanisms to ensure access to and quality of services.
- Identify and address barriers, both policy and systemic, in access to comprehensive sexual and reproductive health services and suggest concrete recommendations to overcome these, including
 - modifying policies that prevent health personnel from providing a complete range of contraceptives such as compulsory registration in camps for accessing long acting contraception and allowing non-government trained health personnel to provide this service.
 - liberalizing restrictive national legal provisions that prevent access to abortion.
- Ensure the quality of services and adherence to standards, including local staff training and capacity building, supervision and mentoring.
- Ensure that refugee camps are safe for women and girls and do not expose them to further risks of gender-based and sexual violence, including child, early, and forced marriage.

Endorsed by:

CARE
Center for Reproductive Rights
IPAS
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⁴⁵ S.C. Pres. Statement 2017/22, U.N. Doc. S/PRST/2017/22 (Nov. 6, 2017).

⁴⁶ *Id.*