UNITED NATIONS HUMANITARIAN RESPONSE TO THE ROHINGYA CRISIS BETWEEN 2001 – 2018

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UNITED NATIONS HUMANITARIAN RESPONSE TO THE ROHINGYA CRISIS BTEWEEN 2001-2018

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Mandela-DuBois Matthews Howard-Mparuri

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INTRODUCTION

A. Goals and Objectives

The primary goal of the research is to explore the differences between United Nations humanitarian assistance received by Rohingya populations who are displaced but remain within Myanmar (known as Burma until 1989) and those who reside in refugee camps in Bangladesh. Pursuant to this goal, this research will document the United Nations (UN) and United Nations High Commissioner for Refugees (UNHCR) Programmatic and financial approaches to the crisis.

B. Rationale and Interests

Interest in the research began during a residency at CARE headquarters in Atlanta. My primary project with the organization included reviewing the human rights violations against the Kachin, Chin, and Rohingya in Myanmar and their impact on these marginalized groups' health and socio-economic status. Many discussions with CARE staff occurred, particularly as violence escalated against the Rohingya in Rakhine State and thousands fled to Bangladesh, a neighbor whose economy cannot accommodate humanitarian relief without international support.

Research on the Rohingya crisis also required consultation with others, including organizations working inside Myanmar, coordinating South Asia refugee relief, and considering establishment of a presence inside Myanmar. Fortunately, Emory University professors interested in human rights and emergency management assistance offered suggestions. Having lived and worked in recovering conflict nations, practitioners' engagement and academicians' interest received warm welcome. It was intellectually cathartic. Off-the-record dialogues with experienced humanitarian professionals revealed valuable lessons, best practices, and generated trepidations regarding security in Myanmar. They also offered thoughtful caution about risk avoidance for

soon-to-be MPH graduates eager to return to international work involving hotspots, including not only Myanmar and Bangladesh but also Democratic Republic of the Congo, Yemen, Iraq, and Syria.

Initially, investigating humanitarian relief in conflict areas ensued produced no research goals. I found myself asking broad questions: How does a crisis emerge as a hotspot? Assuming differences existed between hotspots, how do relief organizations respond to crises laden with environmental hazards, political instability, dominant military, weak governance, human rights violations, unfriendly government, and rejection of humanitarian relief? How do relief organizations determine crisis nomenclature? Are relief workers safe when responding to crises?

Dialogues with humanitarian professionals also revealed the influential role of the United Nations in humanitarian relief. Next, consultations with librarians at the Dag Hammersjold Library, UN Information Library, and Government Documents Division at the Library of Congress occurred. These conversations and research firmly suggested humanitarian relief organizations and the global health community may have been very much influenced by the UN response to the Rohingya crisis. Because U.N. High Commissioner for Refugees (UNHCR) is the primary agency working within the Rohingya crisis, it is the agency of focus in this thesis.

C. Research Question

The research question is as follows:

Primary Research Question: What are the similarities and differences between the United Nations' response to displaced Rohingya in Myanmar and Rohingya refugees in Bangladesh?

To answer the primary research question, I analyzed annual budget allocations to internally displaced Rohingya in Myanmar and Rohingya residing in refugee camps in Bangladesh of the United Nations High Commissioner for Refugees (UNHCR) between 2001 and 2018.

D. Outline of Thesis

The thesis is divided into five chapters. Chapter One provides a description of the goals and objectives of the research, why the researcher chose this line of inquiry, what question this thesis aims to answer, and an outline of the document. Chapter Two, Background to the Problem and Significance of the Study, consists of a brief overview of the Rohingya crisis in Myanmar and its impact on Rohingya in Myanmar and Bangladesh. The chapter also explains the importance of the study to the global health community's response to the Rohingya crisis.

A description of the research strategy is provided in Chapter Three. It includes the assumptions and approach to investigating the topic, research methodology, research design and in-depth case study detail, and data collection and analysis. Chapter Four, Results, contains a comprehensive review of relevant findings related to UNHCR annual budgetary allocations for Rohingya-related operations in Myanmar and Bangladesh between 2001 and 2018. Chapter Five serves as a discussion and conclusion. It also comprises reviews of the contribution of the study to existing literature, limitations of the study, and recommendations for future research. Additional sections of note in this document are the List of Tables, Diagrams, and Maps, and References.

Chapter II.

BACKGROUND TO THE PROBLEM AND SIGNIFICANCE OF THE STUDY

A. Public Health Challenges and Forcible Deracination in the Rohingya Context

1. Internal Displacement in Myanmar

As of 2017, there are at least 10 Internally Displaced Persons (IDP) camps offering refuge to 200,000 or more Rohingya, mainly in central and north Rakhine State. (Myanmar Peace Monitor, 2017) Camps in the central part of the state often house returning refugees from Bangladesh, primarily from Cox's Bazar. Northern sites attract Rohingya that could not risk the longer, more hazardous journey to Bangladesh. Both are home to returning refugees who cannot resettle in their home areas due to insecurity or infrastructure damage.

IDP camps are typically found in inhospitable, isolated, and poverty-stricken areas offering few educational and employment opportunities. Also, they operate adjacent to rice paddy fields that draw several vectors, including mosquitoes, bed bugs, lice, and flies. They are prone to frequent flooding and torrential rain, which gives the common appearance of a muddy swamp. The monsoon season with its heavier rains, cyclones, and typhoons exacerbate constant environmental instabilities associated with poor sanitation and water supply systems. (O'Toole, 2013) Flimsy straw-thatched shelters easily topple. Overflooded latrines contaminate homes and common-area spaces, including cooking areas, water pumps, rain catchers used to collect water, and underground and fresh water. These environmental instabilities cause "rapid deterioration" in the camps. (Myint, 2018.) Rapid deterioration includes clean water scarcity due to increased water contamination and spread of additional diseases. Seasonal diseases include dengue fever, typhoid, viral hepatitis, and leptospirosis, which usually affect children 15 years and under more than adults.

Numerous physical and mental diseases are common in all IDP camps throughout Myanmar. (Table II- 2) However, they effect Rohingya more than other ethnic groups. For example, malnutrition is more prevalent in Rakhine State (144,580) than in Kachin State (16,862) and Shan State (3,878). (IDMS, 2018.) Rohingya also commonly suffer from diarrhea, respiratory tract infection, skin infections, mental trauma, and dysentery.

Table II-1: Overall Health Status of Internally Displaced Persons in Myanmar

Physical Health Conditions	Mental Health Conditions
HIV/AIDS	Post-Traumatic Stress Disorder
Malnutrition	Clinical Depression
Tuberculosis	Acute Dissociation
Dysentery	Anxiety Disorder
Malaria	Agoraphobia
High infant mortality	Insomnia
Low life expectancy (<62 yrs)	Substance Abuse

IDMS, 2018)

Increasingly poor living conditions accelerate the spread of communicable diseases among the Rohingya. Primary vectors of disease are open and unsecured water sources, unmitigated insect populations, unsanitary latrine facilities operating above capacity, and contaminated foodstuffs. Also, vaccine use remains low. For example, only 86% of children one year or younger have measles coverage.

In relation to mental health, psychosocial diseases are understudied in Myanmar. (Ngyen, Lee, Schojan, and Bolton, 2018) Even fewer studies focus on IDP mental health. However, available data strongly suggest psychosocial conditions related to the experience of surviving marginalization and displacement run rampant, particularly depression stemming from perceptions of isolation, helplessness, and loss. (IDMS, 2018) Among Rohingya IDPs, pregnant women,

children under the age of 11 years, youth with one or more deceased and/or missing adult relatives, and the elderly are the most vulnerable to mental illness.

To make matters worse, IDPs routinely suffer from lack of access to essential healthcare. No more than 60% of camps offer basic services. For every 10,000 people, there are .5 mental health therapists, .1 psychiatrists, 5 doctors, 8 nurses and midwives, and 6 hospitals. (UN Myanmar In-Country Team, 2017). A combination of factors explains lack of healthcare for the Rohingya. (Brady, 2013; (Independent International Fact-Finding Mission on Myanmar, 2018) First and foremost, insufficient resources and inconsistent global interest in the Rohingya crisis are contributing factors. Second, NGOs and UN health clusters experience serious obstacles when seeking entrance into Myanmar and then permission to travel to Rakhine State and other areas. Even with a travel permit, government controls service providers' operational setup, management, and treatment foci. Third, Rohingya statelessness remains with them wherever they go in Myanmar. Travel within a township to receive health care can be dangerous; travel outside a township for any reason is even more hazardous and requires a permit. Government effectively controls the IDP camps - when they are secure and when they are not. It determines how many Rohingya can travel to and remain in the camps, how many national and international health providers travel to the camps, amount of equipment and medicines transported to the camps, location of camp sites, and layout.

Lack of security additionally contributes to all aspects of IDP camp management and outcomes. Rohingya flee to the safety of IDP camps knowing they have neither equipment nor soldiers to defend themselves against state-sponsored operations. Once there, they discover that IDPs living in camps are tasked to police and protect themselves. (UNOCHA, 2017) They also realize that Rohingya women and children, who are at the greatest risk of physical and mental

harm and the least able to defend themselves, are even more vulnerable in IDP camps patrolled by government soldiers. It becomes painfully apparent that once inside a camp, government soldiers are in even more control of their mobility and access to food. In 2017, for example, the Myanmar government simultaneously closed scores of IDP health clinics, food distribution centers and exit points that Rohingya might have used to escape. (UNOCHA, 2017) To strengthen the impact of cordoning off exits, militia and vigilante groups burned and looted camp facilities. These same groups guarded the roads to prevent Rohingya flight. As a result, Rohingya lived in fear for their lives for months, as well experienced a shortage of medical care, food and water, and basic supplies.

In addition, the all-too-often cautious international response to the Rohingya crisis plays a role in limited healthcare in the IDP camps. Simply put, Myanmar is unlikely to be a willing, helpful host to healthcare providers. Because government and government sponsored groups remain in control of IDP camp security, final approval regarding the management of the camps always lies in their hands.

Myanmar's security forces murdered approximately 7,000 Rohingya in the first month of its August 2017 "clearance operations," which generated a mass exodus of over 700,000 and internal displacement over 125,000. Working independently and with the Ministry of Health and Sports, MSF established fixed and mobile health delivery operations in Rakhine and later in neighboring states. Although over 75,000 received treatment, government halted all services by application of travel bans on all MSF providers. (Doctors Without Borders, 2018.) A similar MSF operational banning occurred in 2014. (Perlez, 2014.)

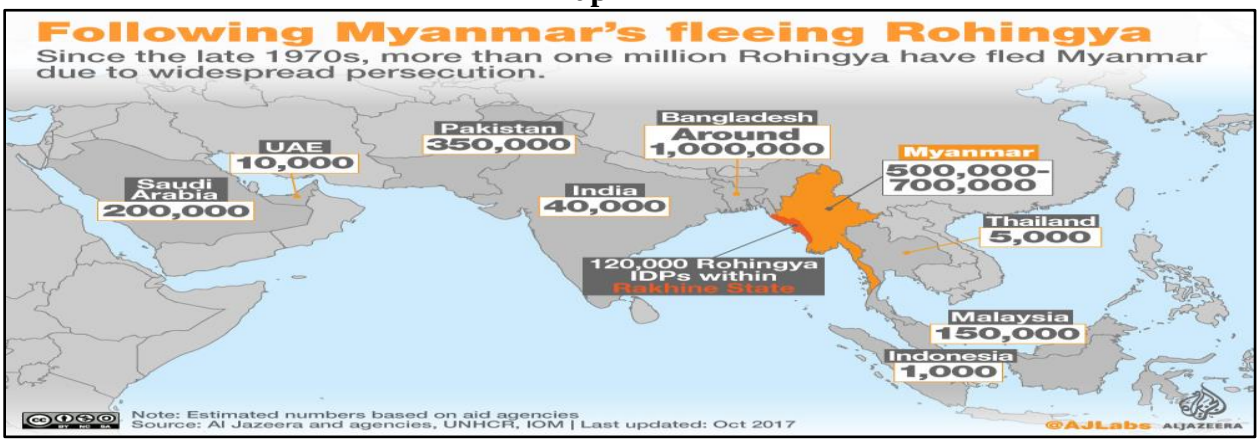
MSF is not the only humanitarian organization banned by the Myanmar government. Turkey offered to establish hospitals and clinics and rebuild homes and public buildings in Rakhine

State, which initially gained the approval of government. (Human Rights Watch, 2016) However, disgruntled Bamar demonstrated against the plan because they claimed stateless people cannot own property and new homes. As a result, government banned Turkey and its proposed operations. At other times, government has curtailed operations by UNHCR, WFP, and other humanitarian organizations. (Human Rights Watch, 2016; UN News, 2016)

2. Refugee Life for Rohingya in Bangladesh

By 2018, over 1,300,000 million Rohingya fled Myanmar. The major migration years were 1948-50, 1972-76, 1991-92, and 2014-18. By 2015, as shown in Map II-1, over six nations hosted the majority of Rohingya refugees. Today, of the six, the largest number of refugees reside in Bangladesh.

Map II - 1

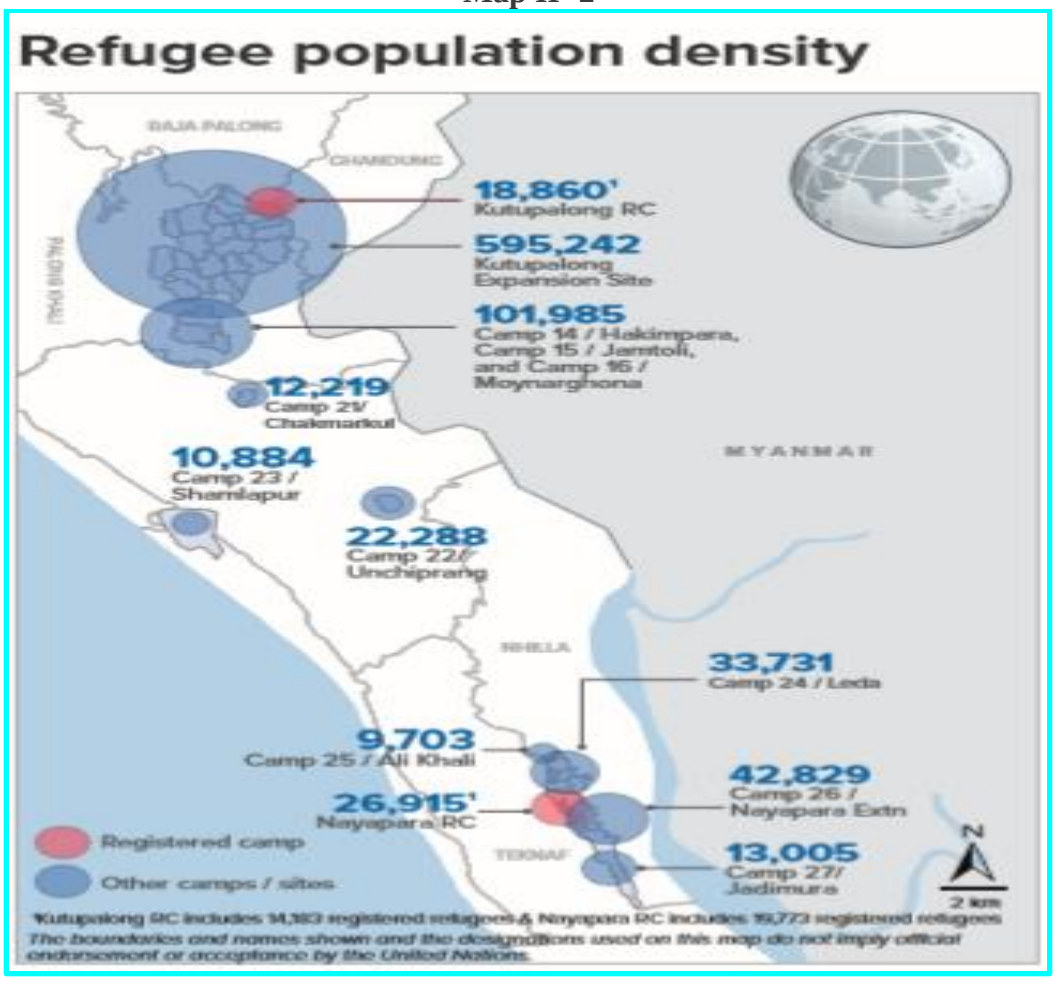


(Al-Jazeera,2017)

Approximately 20 refugee camps and nearby peri-camps operate in Bangladesh. The largest and most organized camps are mainly located along the northern border and coast facing Myanmar. As shown in Map II-2, they range in occupancy from approximately 9,000 to 600,000. Cox's Bazar, formerly a luxurious coastal site for tourists in northwest Bangladesh, is the largest refugee site in the world. (Magan, 2018) Kutupalong and Nayapara are its major refugee camps. Each individual house in the camps, originally made for 10 people, currently houses 20-30 people.

(UNHCR, 2018) Ninety percent of the total population (853,705) live in makeshift peri-camps that are not government recognized. They are at a higher risk of exposure to life-threatening dangers and poor preparation for repatriation. Dangers include food insecurity, and environmental disasters, such as landslides, and floods during monsoon season.

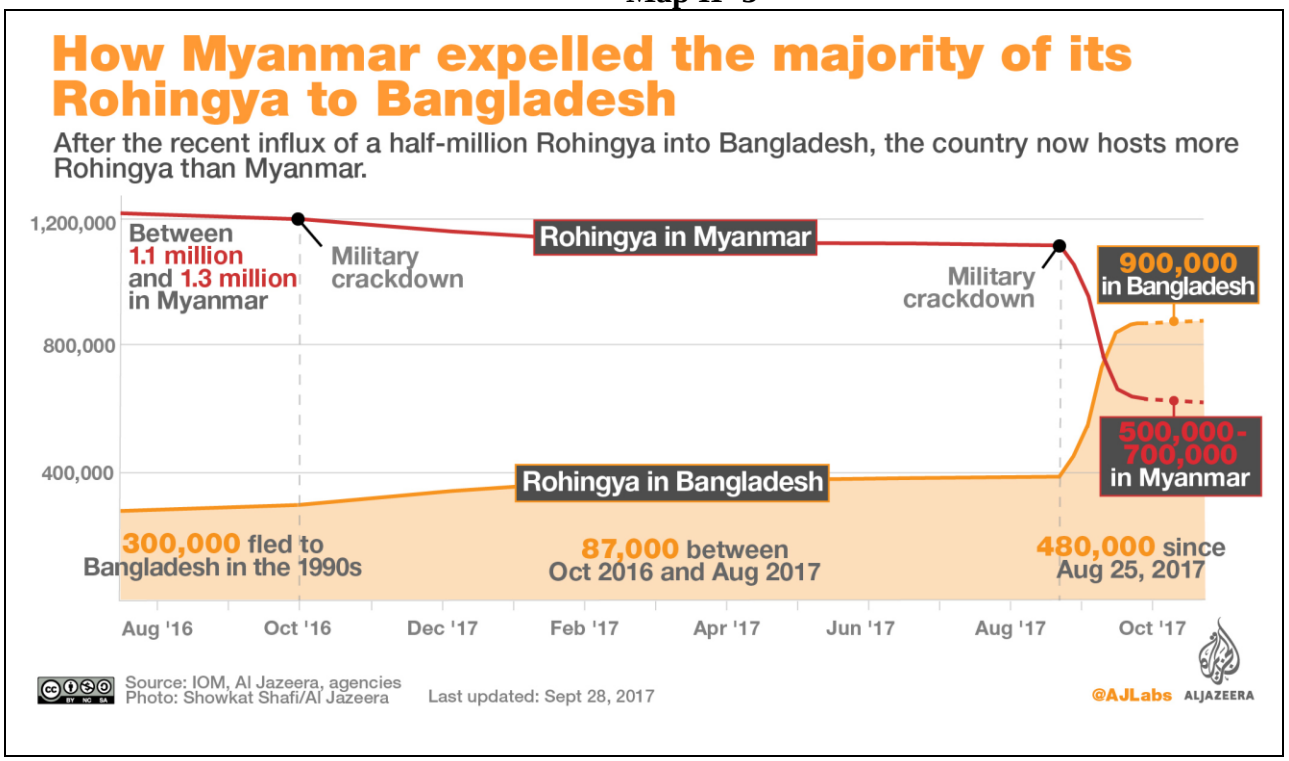
Map II -2



(UNHCR, 2018)

Due to repatriation, numbers of refugees in camps and peri-camp areas in Bangladesh markedly declined in intervals. For example, over 250,000 Rohingya arrived in the 1990s with a repatriation rate of 75% in the early 2000s. However, as shown in Map II-3, the Rohingya refugee population skyrocketed by 2017.

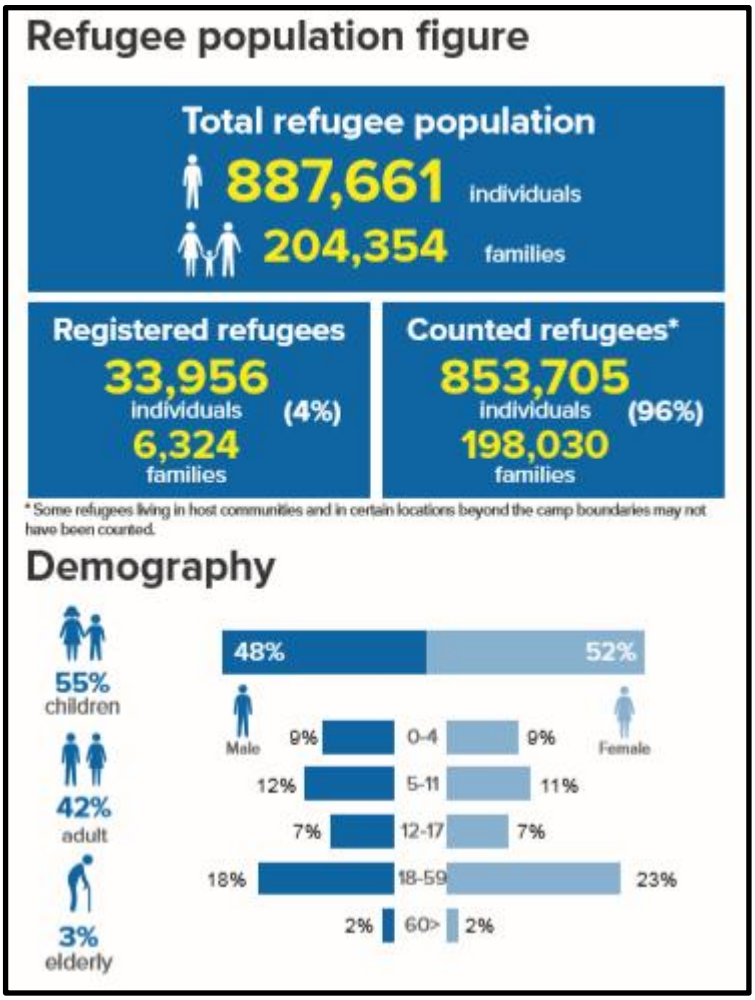
Map II- 3



(Al Jazeera, 2017)

By 2018, more Rohingya inhabited Bangladesh than in Myanmar and other refugee hosting nations. Eighty percent of the refugees currently in Bangladesh arrived within six months in 2017. Approximately 12% of the current 1,000,000 plus Rohingya arrive in family units while 88% enter as unattached individuals. (UNHCR, 2018) To date, only 4% are fully documented through registration. Because increasing numbers of Rohingya fear camp authorities and dangers possibly encountered while traveling between camps and peri-camps, 96% are not fully counted. As shown in Diagram II-1, children (55%) outnumber adults (42%) and elderly (3%). Females (52%) and males (48%) are almost equally distributed. In terms of age, 20% of males and 24% of females are 18 years and over; males are 28% and females 27% of the 0 to 17 years age group.

Diagram II-1



(UNHCR, 2018)

The majority of Rohingya inundating Bangladesh in the most recent exodus, 2017 and 2018, originated from three communities no more than 35 miles apart in Rakhine State. The communities and percent fleeing are Maundaw (67%), Buthidaung (26%), Rathedaung (5%). (UNHCR, 2018) Located near the site where military clearance operations resulted in over 1,000 murders in 2016, refugees from these areas recount tales of immense physical intimidation, village burnings, disappearances, and near starvation due to logging, fishing, and other bans. (Das, 2017; Radio Free Asia, 2018) In terms of family size, 39% of the families are four to five in size; 37% hold one to three persons and 2% contain five to eight. (UNHCR, 2018) Thirty-one percent of the

families registered at least one person with a protection vulnerability. The vulnerabilities and percentage of families with them are as follows:

- Single mother (16%)
- Serious medical condition (5%)
- Older persons at risk (4%)
- Physical or Mental Disability (4%)
- Child separated from family (2%)
- Older persons with children (2%)
- Unaccompanied child (1%)
- Single male parent with infant (1%)

(UNHCR, 2018)

A description provided by the United Nations Children's Fund suggests the magnitude of the problem that externally displaced populations face:

> Thousands … arrive daily … . The vast majority are women, including mothers with newborn babies, and children. And they are joining an existing refugee population, some of whom have been in the camps for years, others displaced by recent flooding … While most of the Rohingya refugees are arriving on foot, walking for several days through jungles and across mountains, thousands are making risky voyages by fishing boat across the Bay of Bengal. Many have died along the way, drowning at sea when their boats capsize. The refugee camps and makeshift settlements in Bangladesh are well over capacity. There is tremendous pressure on already scarce resources. There are shortages of food, water and other necessities. The overcrowded, unhygienic conditions are increasing the risk of cholera and other disease outbreaks. Malnutrition and exhaustion make children especially vulnerable.
>
> (UNICEF, 2017)

No more than 12% of Rohingya in Bangladesh are literate; hence, educational need is exceedingly great. (Magan, 2018) By 2000, primary schools offered instruction up to Grade 5 while vocational education included tailoring and soap making. Instructional funding was based on the number of documented refugees (33,956), although undocumented refugees could theoretically have equal access to opportunities offered. As a result, classes were overcrowded and available classrooms limited. By 2016, less than 50% of the original classes remained due to the mass arrival of Rohingya. To accommodate them, authorities converted schools to communal living quarters. New challenges appeared by 2018. Matriculated students from elementary and high school education faced limited choices if they desire additional education. Vocational

education graduates could not practice their trades because they could not invest in equipment. Even if they could obtain equipment, government policies prevent them from employment outside designated work areas near the camps.

In emergency and crisis settings, humanitarian aid providers use five crucial domains to determine environmental and health needs and establish interventions. They are: 1) water and sanitation; 2) food and nutrition; 3) shelter and non-food items; 4) access to health services; and 5) information. (Chan et. al, 2017) These domains are all already compromised for the Rohingya when they arrive due to environmental challenges and physical and mental trauma experienced in Myanmar and during cross-border flight. Upon arrival, they face seven acute humanitarian risks shown below. These risks are likely to compromise their physical and mental health status even more.

Diagram II-2: Most Acute Humanitarian Risks to Rohingya Refugees

(UNHCR, 2018)

Food and water access is another continuing problem in the Bangladeshi camps due to inadequate food supply and cross contamination of drinking and toilet water. As a result, food, which is already in short supply, is cooked and served in unsanitary feeding centers. Sixty percent

of Rohingya child refugees suffer from malnutrition and stunted development. (Mahmood, 2017) Often one toilet is available for every 37 refugees, which exacerbates sanitation and eventually encourages dysentery and other water-borne diseases. The mortality rate for children younger than five is between 135 and 225 deaths per 1,000 births. Over a third of the youth and adult population suffer from acute respiratory infections. (Chan et. al, 2017) In addition, vaccine-preventable diseases frequently spread.

Humanitarian needs in refugee camps continue to grow exponentially, particularly for women and children. (Chan et al, 2017) Females lack gynecological care, which potentiates harm caused by sexual violence. In 2017, roughly 16,000 births occurred - an average of 60 a day. Of this total, only 3,000 were born in health facilities. Needs will continue to grow in the future due to babies coming to term resulting from acts of sexual violence shortly before the most recent wave of Rohingya exodus.

B. Significance of the Study

This thesis highlights the importance of the destination of funds designated for humanitarian assistance because funding goals for refugee camps can significantly differ from funding goals attached to internal displacement. It also emphasizes the use of financial allocation as a variable to determine involvement in humanitarian relief. Finally, it sheds light on the magnitude of the Rohingya crisis and sheer amount of resources dedicated to its alleviation. The purpose of this work is not to explain why the United Nations changed its funding pattern associated with Rohingya humanitarian relief. However, it lays the groundwork for others to consider the factors that influence the world community's response to humanitarian crises.

CHAPTER III.

RESEARCH STRATEGY

A. Theoretical Approach and Assumptions

With increasing globalization since the end of World War II, providing humanitarian assistance became comes more formidable and complex, widespread, and far too costly for organizations to serve in isolation of their peers. (Martin, Weerasinghe, and Taylor, 2014) Several information services provide data pertaining to post-colonial societies' political and economic development. They include the United Nations Office for the Coordination of Humanitarian Affairs' Financial Tracking Service, Organization for Economic Co-operation and Development, and Fragile States Index. (Norris, Dunning, and Malknecht, 2015**;** Development Assistance Committee, 2015**;** The Fund for Peace, 2018) Their data suggest protracted humanitarian crises are also far more likely in nations burdened with ex-colonial histories; crises in these nations will not only endanger humanitarian organizations' effectiveness but their security as well.

Over 1.2 billion people reside in fragile, ex-colonial societies. These societies are often greatly influenced by United Nation's relief efforts. Due to the ever increasing magnitude of contemporary emergencies, most responses to the world's humanitarian crises necessitate the following: 1) United Nations' leadership, coordination, and financial buy-in; 2) the global community of humanitarian aid providers' professional skills for on-site implementation of projects; and 3) all actors critical understanding of the historical causes of the crises and the reasons for their protracted nature.

B. Research Methodology

The research question is as follows:

Primary Research Question: What are the similarities and differences between the United Nations' response to displaced Rohingya in Myanmar and Rohingya refugees in Bangladesh?

This thesis is framed within the case study method. This methodology was chosen because it allows for focused, detailed data collection and fact-based analysis that is guided by theme or topic. George and Bennett also describe the case study method, quantitative and qualitative research, and theoretical modeling as reinforcing and complementary (George and Bennett, 2005).

It is important to note that George and Bennett advocate within-case analysis – comparative analysis within the case study to enrich findings. (Boblin, et. al, 2013) Using comparative analysis within the case study method, this research offers a review of the Rohingya-focused humanitarian crisis in Myanmar and the global health community's response to it over time. Plus, it allows a comparative analysis of that response based on two levels - the displaced Rohingya confined in Myanmar and the Rohingya refugees living in Bangladesh.

The case study method is also particularly helpful when applied to health-related research in the clinical and field setting. As noted by Crowe et.al, "The case study approach is particularly useful to employ when there is a need to obtain an in-depth appreciation of an issue, event or phenomenon of interest in its natural real-life context." (Crowe et. al,. 2011)

C. Research Design

1. Case Study Sites

Sites integral to this case study lie in Bangladesh and Myanmar. In Bangladesh, the focus is in on refugee camps housing Rohingya who fled from Myanmar throughout the cyclical humanitarian crises in the area. In Myanmar, this study's cornerstone are camps for internally displaced Rohingya.

2. Data Sources

Primary data sources for this thesis come from UN organizations and agencies, particularly UNHCR. Their documents include annual appeals, annual budget reports, donor appeals, general

assembly meetings and summaries, and discussions with contacts. ReliefWeb, humanitarian organizations' reports, periodicals, relevant law and policy documents, and peer-reviewed journals are examples of supporting data sources. I used the flexibility of the Summer 2018 semester to visit several libraries in Atlanta, New York, and Washington, D.C. These libraries offered invaluable access to primary and secondary data. Libraries of particular note included the Library of Congress, Dag Hammerjold Library, and UN Information Library.

3. Data Collection and Analysis

Data were collected from UN in the above listed locations. Data collected remotely via internet also provided access to relevant news reports and inter-organizational findings. The analysis of the aforementioned sources allows for both quantitative (e.g. figures revealing budgets, dedicated projects, and IDP and refugee populations) and qualitative (e.g. humanitarian policy precedence, relevant cultural practices, and official UN correspondence) data. Analysis of quantitative data consists of a collection and year to year comparison of UN budgetary allocations for Rohingya IDPs in Myanmar and Rohingya refugees in Bangladesh between the 2001 and 2018. Analysis of qualitative data involves a description of pillar programs which govern budgetary allocation and types of humanitarian action Rohingya in Myanmar and Bangadesh receive from the UN.

D. Limitations and Challenges

This study assumes that available data from the United Nations, the United Nations High Commissioner for Refugees, United Nations partner organizations, and organizations reporting on the humanitarian crisis are accurate, available, and straightforward. Due to the political and cyclical nature of the Rohingya crisis, it is anticipated that some data from Myanmar and Bangladesh may require authentication. In addition, obtaining analog (i.e. paper documents and

tape recordings) and highly classified data related to UN proceedings proved problematic due to the researcher's position as a student outside United Nations employment or official authorization. Examples of classified data are UN and Myanmar military participation in the Rohingya crisis, full accounts intelligence agencies' observations of migrant patterns between Myanmar and Bangladesh. A final challenge is the classification of Rohingya in Myanmar. Rohingya in Myanmar are technically stateless, but often fall under the umbrella of IDP programs. The ambiguity is slight, but noted.

Chapter IV.

RESULTS

A. Finding I – UNHCR Pillar Program Classifications

In the 2011, UNHCR introduced its four-pillar budget which increased transparency and organized funding to demonstrate adherence to core UN mandates and, as needed, introduction of non-core activities. These pillars, described below, guided by the UN Integrated Development Plan (UNDP), placed the UNHCR in an active role. Its objectives were to smooth out operational bottlenecks, increase attention to housing and security, and most importantly to ensure repatriation and/or citizenship and reintegration for Rohingya. A brief overview for each pillar follows:

Pillar 1: Refugee Program

Operations and activities in Pillar 1 represent core UNHCR mandates. These mandates direct UNHCR to provide maintenance to refugees to improve camp life and support in preparation for eventual repatriation and resettlement. The support only addresses essential needs required in the early stages of repatriation. Asylum-seekers are also included in Pillar 1's scope of work. Programmatic tasks directed by this pillar strengthen the efforts of asylum-seekers to find safe residence outside the country of origin.

Pillar 2: Stateless Program

Similar to Pillar 1, operations and activities in Pillar 2 represent core UNHCR mandates. Pillar 2 encompasses activities related to persons without citizenship. In the case of Myanmar, it also serves individuals that fall under the classic definition of stateless.

Pillar 3: Reintegration Projects

Actions falling under Pillar 3 do not represent UNHCR core mandates. They address extended support that exceeds basic needs required to repatriate and integrate returning refugees. Despite not representing core mandates, actions in this pillar aimed to enhance the probability of lasting stability for Rohingya.

Pillar 4: Internally Displaced Persons Projects

Projects included in Pillar 4 also are not in the UNHCR core mandate. Pillar 4 encompasses projects that stabilize displaced populations and re-build devastated communities.

B. Finding II: UNHCR Annual Budgetary Allocations for Displaced Rohingya in Myanmar and Rohingya Refugees in Bangladesh between 2001 and 2018

Table IV-1 contains UNHCR annual budgetary allocations in the 2001-2018 period. It is important to note the striking and steady rising trends in overall annual budgetary allocations for Rohingya-related operations over the 18-year span. In *Block 1: 2001-2009*, ranging from US$ 3.6 million to US.$ 6.4 million, annual allocations totaled US$ 41.31 million (mean US$ 4.6 million). In *Block 2: 2010 - 2012*, the span of annual allocations dramatically rose to US$ 16.2 million and then US$ 17.2 million, totaling US$50.59 million (mean US$ 16.9 million). In *Block 3: 2013-2015*, allocations exceeded those in previous years and remained similar for all three years. Combined annual allocations soared to US$204.4 million (mean US$ 68.1 million). *Block 4: 2016-2018* continued the trend established in Block 3. Annual allocations ranged from US$ 46.1 million to US$ 56.05 million, totaling US$ 151.5 (mean US$ 50.5 million).

Although UNHCR implemented its new pillar-based budget in 2010, it is possible to trace non-pillar budgetary allocations and operations designated for Rohingya IDPs in Myanmar between 2001 and 2009, although with less specificity. Between 2001 and 2005, average budgetary allocation recorded US$ 3,926,404. However, average allocations soon increased markedly. For the 2006-09 and 2010-12 periods, the average allocations were US$ 5,447,183 and US$ 16,828,282. Allocations for the 2013-16 and 2017-2018 periods are as follows respectively: US$ 68,121,000 and US $ 47,721,618.

Table IV-1 United Nations High Commissioner for Refugees Budgetary Allocations for Rohingya Crisis-Related Program Activities in Myanmar and Bangladesh, 2000 – 2018 (million US)

Year	Myanmar					Bangladesh				
	-Pillar 1- *Refugee Program*	-Pillar 2- *Stateless Program*	-Pillar 3 - *Reintegration Projects*	-Pillar 4- *IDP Projects*	*TOTAL Myanmar*	-Pillar 1- *Refugee Program*	-Pillar 2- *Stateless Program*	-Pillar 3- *Reintegration Projects*	-Pillar 4- *IDP Projects*	*TOTAL BANGLADESH*
	No distinctions made between Myanmar, Bangladesh, and on-site coordination. Shared total				19,651,486	No distinctions made between Myanmar, Bangladesh and on-site coordination. Shared total.				19,651,486
2000	UV				UV					3,798,775
2001					4,306,747					2,928,029
2002					3,649,062					2,595,166
2003					3,637,851					2,340,969
2004					3,746,390					3,276,601
2005					4,181,974					3,343,316
2006					4,845,122					3,090,368
2007					4,304,946					2,890,103
2008					6,175,264					5,097,910
2009					6,463,400					6,310,669
2010	0	11,379,044	0	4,804,783	16,183,827	8,231,150	49,593	0	0	8,280,743
2011	0	11,392,194	0	5,850,187	17,242,381	10,725,295	27,322	0	0	10,752,617
2012	0	9,847,188	0	7,211,448	17,058,637	14,411,420	55,966	0	0	14,467,386
2013	0	12,064,787	0	14,098,616	68,481,570	12,609,556	94,490	0	0	11,776,942
2014	6,051,000	12,940,291	0	49,073,119	68,108,703	12,385,988	12,510	0	0	11,356,138
2015	10,746,411	13,848,084	0	43,178,231	67,772,726	14,425,575	8,731	0	0	14,434,305
2016	28,978,657	2,610,8460	0	24,458,412	56,047,915	13,605,759	62,188	0	0	13,667,947
2017	22,282,485	3,368,718	0	23,675,472	49,326,676	13,751,629	14,216	0	0	13,765,846
2018	9,780,517	24,801,370	0	11,534,674	46,116,560	220,442,812	0	0	0	220,442.812

(UNCHR, 2018; UN, 2018)

Finding III: Observations and Trends in the Last Eight Years of Response to the Rohingya Crisis

A review of the UNHCR budget by pillars between 2010 and 2018 reveals the following areas of specific operational interest:

Observation 1: No operations appear to have occurred under Pillar 3 - Reintegration Projects.

Observation 2: Looking at years 2010 through 2013, Pillars 2 and 4 comprised UNHCR operations. Populations born without citizenship in Myanmar (Pillar 2) i.e. only Rohingya, received the highest allocations (US$ 44.7 million), averaging US$ 11.2 million. Operations for displaced persons (Pillar 4) amounted to (US $ 32.0 million), averaging US$ 8.0 million).

Observation 3: UNHCR involved three pillars beginning in 2014. From 2014 to 2016, which were Pillar 1- refugee Programs (US$ 45.78 million; average US$ 15.26 million); Pillar 2- stateless Programs (US$ 29.40 million; average - US$ 9.80 million); and Pillar 4 - IDP projects (US$ 116.71 million); average US$ 39.0 million). By this period, Pillar 4 operations stabilizing displaced Rohingya and areas overwhelmingly dominated other operational expenditures**.** Combined totals for Pillars 1 and 2 in Year 2014 (US$ 18,991,291 million) represented only 38% of the year's assignment to Pillar 4 (US$ 49,073,119). The next year, allocations for Pillars 1 and 2 (US$ 24,594.495) were 56% of budgetary spending in Pillar 4 (US$ 43,178,231).

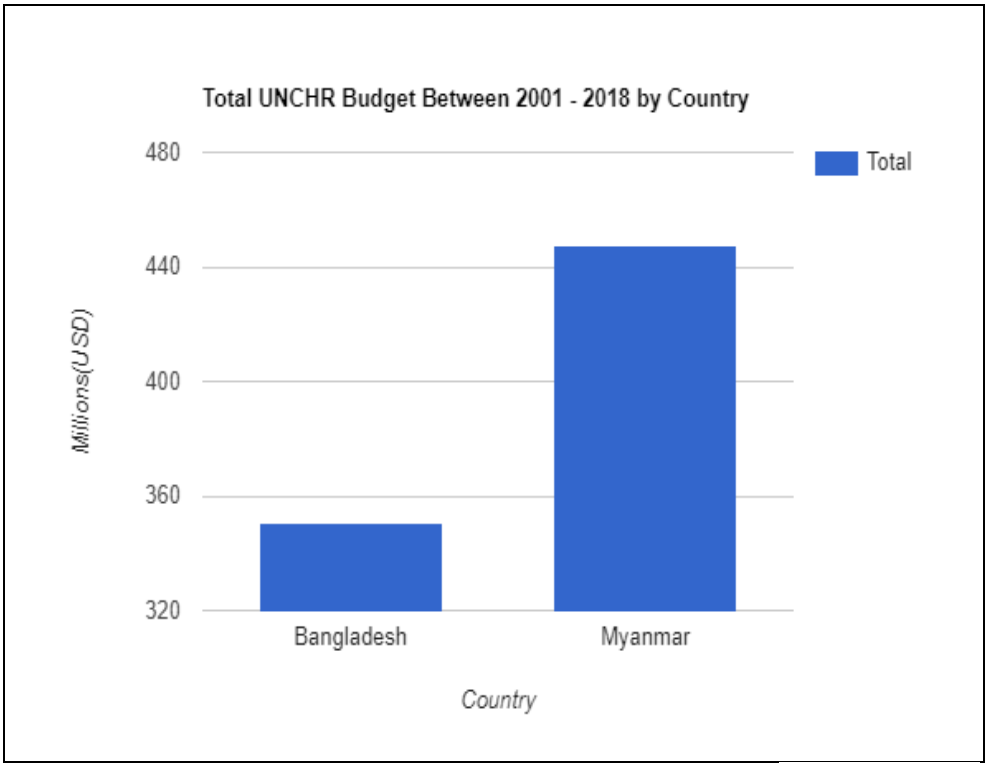
Observation 4: In the 2017 - 2018 period, operations are relatively more balanced when comparing Pillars 1 and 2 with Pillar 4.

It is important to note that beginning in 2013, the clear majority of UNHCR operations and activities demonstrably stood outside its core mandate as represented in Pillars 1 and 2. This point is made in light of the substantive dominance of Pillar 4 - IDP Projects in the annual budgets. Pillar 4 is the primary driver of increases beginning in 2013. With the exception of 2016, allocations for Pillar 4's operations and projects are noticeably greater than those in Pillars 1 and 2, which contain UNHCR's core mandate. For example, in 2014, Pillar 4 received US$ 49.1 million while the combined total for Pillar 1 and 2 reached only US$ 19 million.

Finding IV: Comparison of UNHCR Operations for Displaced Rohingya and Rohingya Refugees in Bangladesh

In terms of comparing total allocations assigned to Rohingya-focused programs in Myanmar and Bangladesh, allocations for Myanmar, primarily funds for IDPs, were greater than allocations for Rohingya refugees in Bangladesh. Diagram IV-1 illustrates the differences between UNHCR budgets for the Rohingya in each country.

Diagram IV-1

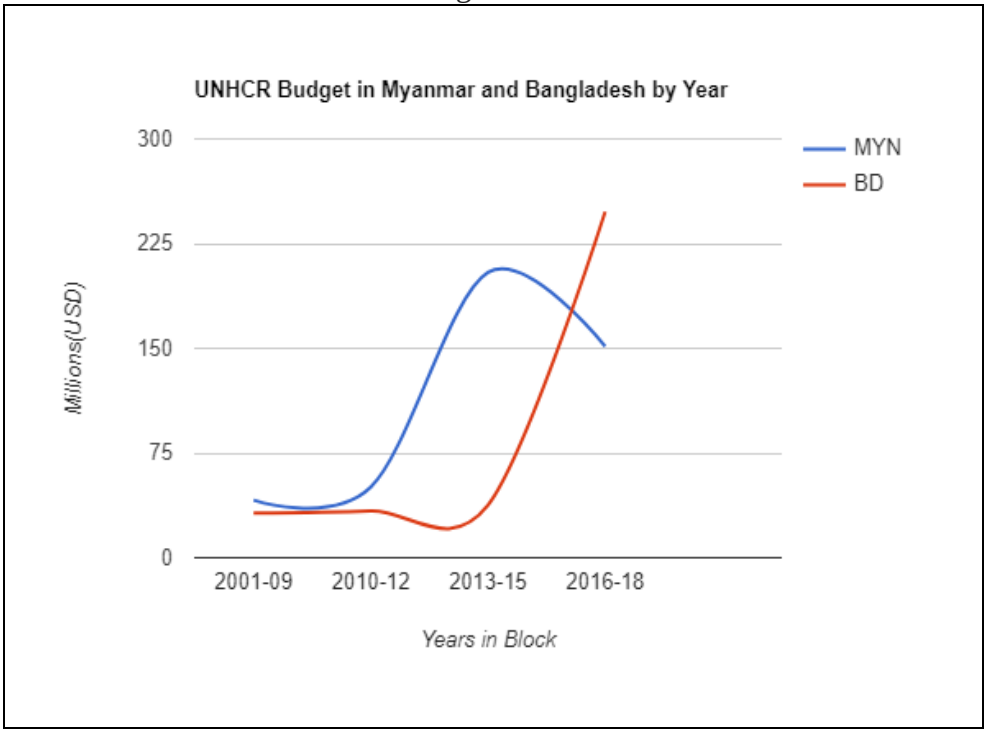


UNHCR. 2018.

A compilation of funding data for both countries between 2001 and 2018 is provided in Table IV-2. Stark differences between budgets grow further as we follow the crisis along the temporal blocks. The largest shifts occur between Blocks 3 and 4. Simultaneously, a sharp increase of refugees arrived in Bangladesh from Myanmar. In the instance of Block 4, 50% of the Block 3 program budget for Rohingya in Myanmar shift to Rohingya in Bangladesh. UNHCR allocations to Rohingya programs in Myanmar surpassed allocations for Rohingya programs in Bangladesh with one exception in 2018 when mass migration numbers jumped exponentially. Even when UNHCR directed US$ 220,442,812 in Year 2018, however, 2001-2018 total funding aimed at programs in Myanmar exceeded allocations for programs in Bangladesh.

Table IV-2: UNHCR Rohingya-related Allocations to Myanmar and Bangladesh by Period, 2001 - 2018 (US$ million)		
Years	**Myanmar** (US$ million)	**Bangladesh** (US$ million)
Block 1: 2001-09	41,310,756	31,873,396
Block 2: 2010-12	50,589,611	33,500,746
Block 3: 2013-15	204,362,999	37,567,385
Block 4: 2016-18	151,491,151	247,876,605
TOTAL:	447,754,517	350,818,132

Diagram IV-2



(UNHCR, 2018)

In Year 2018, UNHCR directed US$ 220,442,812. The impact of this steep funding increase is demonstrated in Diagram IV-2. The funding change suggests the possibility of a reversal within the next 10 years. This shift does not denote a decrease of efforts in Bangladesh; just an intensification of programs for displaced Rohingya living within Myanmar.

Chapter V.

DISCUSSION AND CONCLUSION

A. Discussion

Between 2001 and 2018, more money was spent on Rohingya IDPs in Myanmar than Rohingya Refugees in Bangladesh. UNHCR entered the Rohingya crisis with core mandates driving its analysis of need and project interventions. From 2001 - 2015, more money was spent helping Rohingya IDPs in Myanmar than on Rohingya Refugees in Bangladesh. As the crisis intensified over the years and more Rohingya fled Myanmar, objective conditions forced UNHCR to broaden the scope of its operations. From 2016 to 2018, UNHCR shifted its focus and spent more resources on Rohingya Refugees in Bangladesh than Rohingya IDPs in Myanmar.

Using the above observation to compare funding allocated for Rohingya in Myanmar and Bangladesh, in Bangladesh UNHCR did not venture from its two core mandates. As indicated in allocations for Rohingya refugees in the country between 2010 through 2018, its operations always remained tied to Pillars 1 and 2, which contain the core mandates - improving refugee health and stability to instill successful repatriation.

UNHCR operations in Myanmar originated from Pillars 1 - specific and direct to address the rigors of repatriation and resettlement, Pillar 2 - identify safe haven beyond Myanmar's borders for stateless persons, and Pillar 4 - attending to complex needs of IDPs. Additionally, allocations designated for Pillar 4 were larger than the combined totals for Pillars 1 and 2.

Rohingya focused initiatives in Myanmar and Bangladesh grew as time passed and the crisis increased in intensity. Neither's funding dropped below the amount granted in 2001. After 2017, the aim both initiatives was to increase efforts and results exponentially in response to the overwhelming increase of Rohingya in need. Throughout the response to the Rohingya emergency,

the end goal for programs targeting both IDPs and Refugees remained parallel. The shared goal of programs was to bring stability to Rohingya via healthcare, citizenship programs, social and economic empowerment, human rights advocacy, and peacekeeping; independent of Rohingya technical classification as refugees or otherwise. Programs within the initiatives used differing methods; sometimes drastically so. In addition, the size of programs differed greatly. IDP-focused programs in Myanmar were smaller in scope but cost much more as the amount of Rohingya leaving the country increased over the years and the acute nature of their needs grew as time passed. Programs in Bangladesh were massive in scope; particularly those related to Cox's Bazar. However, programs in Bangladesh required smaller UN allocations because they were older and operated in tandem with the Bangladeshi government and other resourceful organizations.

The comparatively larger amount of money spent on Rohingya IDPs in Myanmar and recent pivot of funds towards Rohingya Refugees in Myanmar are significant because they speak to the evolution of the UNHCR's perception of the Rohingya crisis. It was initially thought that the crisis could be resolved via humanitarian programs within the country of Myanmar. As time progressed and government efforts to oppress Rohingya increased, more Rohingya fled Myanmar. The UNHCR then noticed both an increased number of Rohingya in Bangladesh and even greater refusal on the government's part to contribute to humanitarian efforts. I predict that future UNHCR funds will follow the trend set between 2016 and 2018 and even less money will go towards Rohingya-focused humanitarian efforts in Myanmar. In addition, I also predict that other humanitarian organizations will follow the lead of UNHCR and direct their resources towards Rohingya in Bangladesh. I am not sure what this implication will mean for Rohingya still in Myanmar; if conditions continue to decline, we can expect those that are able to flee the country to do so.

B. Conclusion

Research Question

This research addressed one primary question: What are the similarities and differences between the United Nations' response to displaced Rohingya in Myanmar and Rohingya refugees in Bangladesh? To answer this question, the research examined the UN response to the Rohingya crisis by analyzing budgetary allocations established for UNHCR operations in Myanmar and Bangladesh between 2001 and 2018.

Programs within the initiatives used differing methods; sometimes drastically so. In addition, the size of programs differed greatly. IDP-focused programs in Myanmar were smaller in scope but cost much more as the amount of Rohingya leaving the country increased over the years and the acute nature of their needs grew as time passed. Programs in Bangladesh were massive in scope; particularly those related to Cox's Bazar. However, programs in Bangladesh required smaller UN allocations because they were older and operated in tandem with the Bangladeshi government and other resourceful organizations.

The UNHCR was an excellent choice to use in a case study to identify similarities and differences in UN allocations between Rohingya populations in Myanmar and Bangladesh for several reasons. It is a unique agency. UN agencies must be associated with at least one of the five operational functions of the UN: humanitarian, development, peacekeeping, technical or normative, treated-related, and knowledge creation. Most agencies carry multiple operational functions. In a humanitarian crisis, their budgetary allocations and energy are not only dedicated to the humanitarian effort but also to, for example, development and technical operations. UNHCR is one of the few UN agencies solely dedicated to humanitarian operations. It is the only agency involved in the Rohingya crisis that is solely dedicated to providing humanitarian assistance. Other

agencies involved in the crisis carry multiple operational goals. For example, UNFP and UNICEF are focused on humanitarian and development support, while IOM addresses humanitarian, technical, development, and normative issues.

Limitations of the Study

As anticipated, obtaining accurate longitudinal data on the Rohingya crisis proved difficult. Many obstacles contributed to this difficulty. The most concrete of these was UN clearance; more specifically a lack thereof. The UN does an excellent job of securing any information it deems sensitive. General UN policy states that individuals without official authorization do not have full access to the entirety of the organization's data. Securing data can sometimes equate to a complete denial of access. In other situations, it can mean submerging data within greater collections of information. As such, it took a great amount of time - and even greater levels of luck - getting relevant data. The aforementioned need for time and luck was particularly prevalent in relation to obtaining deliberation proceedings. Leveraging contacts within the Library of Congress and United Nations offices in New York, Washington, D.C., and Geneva helped greatly in this process.

An abstract obstacle to research was the political nature of the crisis. Myanmar effectively downplays its repressive response to internal conflict as it champions a progressive international agenda in the UN and elsewhere. Unlike other complex emergencies, the Rohingya crisis is both supported by Myanmar's government, but also officially disavowed. This leads to data misrepresentation related to the situation both in and outside of Myanmar and Bangladesh. This, along with the associated intricacies between the UN and UNCHR and Myanmar's government, created a proverbial haystack that needed to be filtered through.

Future Directions for Research

Future research will focus on the direction of the Rohingya crisis response, the humanitarian community's plans related to preventing complex emergencies, and what smaller actors in the global community can do to alleviate humanitarian suffering. The first and second facets of future research stem from an interest to further push the conceptual framework discussed in this thesis while increasing its generalizability. Budgetary allocations grow by the year and in essence, jump from emergency to emergency in an extremely reactive way. As a community driven by the tenets of public health and human rights, this game of "whack-a-mole" cannot go on forever; at some point, we must focus purpose and move towards changing the status-quo for those who suffer. While this process occurs, the third focus of future research will be key. The humanitarian community's efforts may be emboldened by an empowered global populace. As such, research should investigate the best ways to achieve this.

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