UNHCR
The UN Refugee Agency

CULTURE, CONTEXT AND MENTAL HEALTH OF ROHINGYA REFUGEES

A review for staff in mental health and psychosocial support programmes for Rohingya refugees

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Cover photo: Thousands of new Rohingya refugee arrivals cross the border near Anzuman Para village, Palong Khali, Bangladesh. As an estimated 500,000 Rohingya sought safety in Bangladesh between late-August and October 2017, UNHCR worked with the authorities to create a transit centre to prepare for a further influx, as some 11,000 people crossed the border on 9th October. © UNHCR/Roger Arnold, 9 October, 2017

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LIST OF ACRONYMS

ACF	Action Against Hunger (Action Contre La Faim)
GAM	Global Acute Malnutrition
GOB	Government of Bangladesh
IASC	Inter-Agency Standing Committee
IOM	International Organization for Migration
LSHTM	London School of Hygiene and Tropical Medicine
MOHFW	Ministry of Health and Family Welfare
MHPSS	Mental Health and Psychosocial Support
MSF	Médecins sans Frontières
NGO	Non-Government Organization
NLD	National League for Democracy
PTE	Potentially Traumatic Events
PTSD	Posttraumatic Stress Disorder
RA	Research Assistant
RRRC	Refugee Relief and Repatriation Commissioner
SAM	Severe Acute Malnutrition
SGBV	Sexual and Gender-based Violence
UK	United Kingdom
UNHCR	United Nations High Commissioner for Refugees
UNSW	University of New South Wales
USA	United States of America
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

In August 2017, a major humanitarian crisis in the Rakhine State of Myanmar triggered a mass exodus of around three-quarters of a million stateless Rohingya refugees into neighbouring Bangladesh, adding to the estimated 200,000–300,000 Rohingya refugees in Bangladesh who had fled Myanmar earlier and the estimated 73,000 Rohingya refugees in Malaysia.

Limited information is available on the culture and mental health of the Rohingya, which poses significant challenges to the provision of Mental Health and Psychosocial Support (MHPSS) and related services to this group. Therefore, UNHCR commissioned this document with the aim of providing a concise review of the literature concerning the culture, context, mental health and psychosocial wellbeing of Rohingya refugees.

The content of the document is based on an extensive review of the published and grey literature including various sources of information provided by United Nations agencies, non-governmental organizations, and governments. The search included published and unpublished archival data, academic articles, documents, and other relevant documentary materials from disciplines ranging across the social sciences, anthropology, ethno-cultural studies, psychology and public health. A core group of multidisciplinary personnel wrote and reviewed draft versions of the document after which an advanced draft was sent out for wide review among academics, NGO staff and UN experts.

The first part of the review provides a broad overview of the general context focusing on the historical, geographic, demographic, economic, political, religious, gender, and cultural factors relevant to the Rohingya people. The Rohingya are the largest Muslim group in Myanmar. Their history is complex, involving exposure to a long legacy of human rights violations including torture, rape, assault, extrajudicial killings, and restricted access to education and health care. Many, and probably most. Rohingya have been displaced, either within Myanmar or as refugees now residing in Bangladesh, Malaysia and other countries.

The second part of the report focuses on the mental health of the Rohingya people, including


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the epidemiology of mental health conditions, the range of risk factors (e.g. exposure to potentially traumatic events, poverty, shortage of food, shelter, healthcare, loss of identity, being stateless, sexual and gender-based violence), and protective factors (e.g. religion, spiritual adherence and practice, formal and informal social support). This section also describes the various terms in the Rohingya language to indicate mental health conditions. These concepts are not equivalent to the psychological concepts of depression, posttraumatic stress disorder or anxiety disorder, although they could overlap to some extent overlap with them. Thus, MHPSS service providers need to clearly explain what they mean when they use international constructs of mental ill-health in conversations with Rohingya clients. Rohingya cultural idioms of distress (common modes of expressing distress within a culture or community) and explanatory models (the ways that people explain and make sense of their symptoms or illness) are closely related to religious ideas and concepts held by the person. The Rohingya worldview of the self/person tends to distinguish between the brain (*mogos/demag*), the mind-soul (*dilor/foran*), and the physical body (*jism*). It is important that MHPSS providers working with Rohingya have a global idea of these concepts since they influence the expectations and coping strategies of their Rohingya clients.

The third part of the review describes the current humanitarian context, particularly in Bangladesh where multiple agencies are involved in MHPSS interventions within various sectors such as health, nutrition, education and protection (including child protection, community-based protection and prevention and response around sexual and gender-based violence – SGBV).

This review highlights the importance of understanding the key sociocultural aspects of mental health and wellbeing to assist humanitarian agencies, government, and non-government organizations in providing effective culturally informed services to the Rohingya. An overarching aim in providing this information is to encourage a consistent and coordinated multi-sectoral approach to address the mental health needs of the Rohingya.


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1. INTRODUCTION

The Rohingya constitute the largest Muslim minority group in Myanmar. Over the last decades, discrimination and oppression have resulted in the mass displacement of Rohingya from and within Myanmar, with substantial numbers fleeing to neighbouring countries and beyond, including Bangladesh, Saudi Arabia, Pakistan, Malaysia, India, Thailand, and Indonesia [1–3]. Since late August, 2017, the exacerbation of violence and military operations in the northern townships of Rakhine State, where the majority of Rohingya resided, has led to more than 700,000 Rohingya refugees fleeing across the border into Bangladesh [4].

1.1 Rationale for the desk review

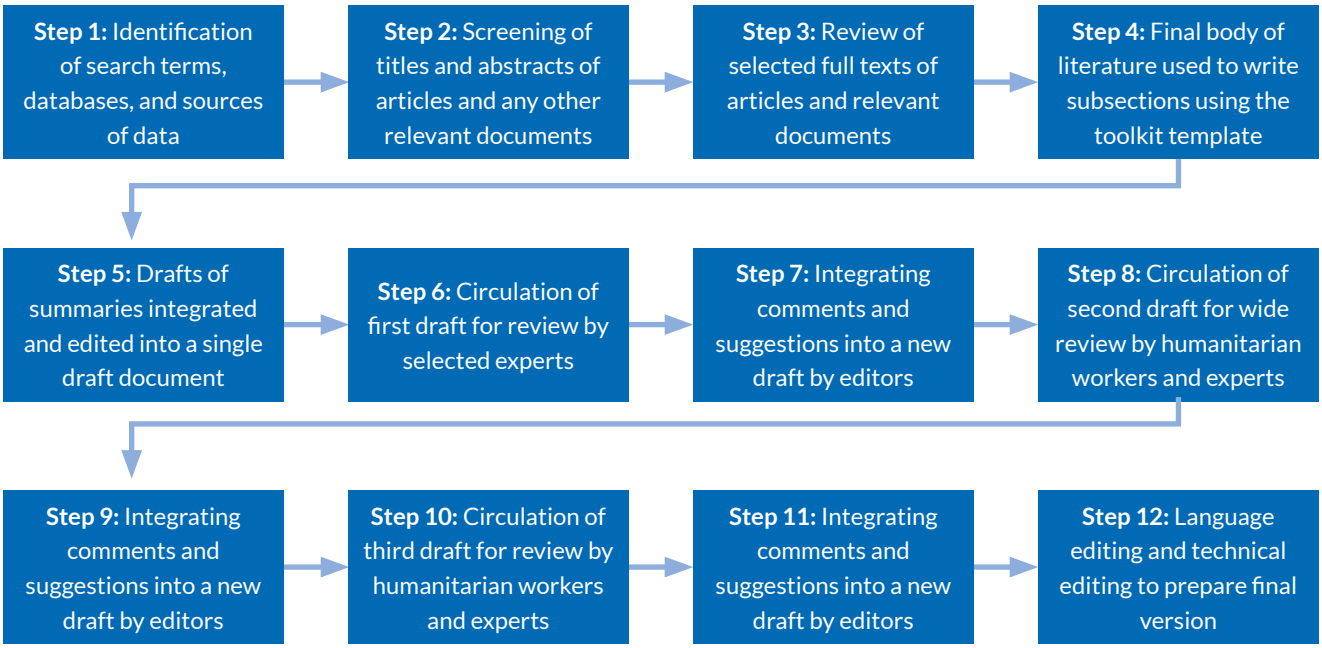
Although documentation of the history of human rights violations against Rohingya is extensive, there is a lack of information concerning the mental health and psychosocial status of this group. The key objective of this desk review is to synthesize what is known about the mental health and psychosocial wellbeing of the Rohingya, situating this knowledge within the broader socio-political and cultural context. The goal is to assist humanitarian actors and agencies in providing culturally relevant Mental Health and Psychosocial Support (MHPSS) for this group. While the focus of this review is on Rohingya refugees in Bangladesh, we expanded the scope of our review to include other relevant information concerning Rohingya communities within Myanmar and in other countries of displacement.

1.2 Methodology

We conducted a comprehensive desk review using the WHO-UNHCR toolkit for MHPSS needs and resource assessments [5]. The process started in October 2017 with an extensive search of all sources of information including peer-reviewed literature, grey literature (such as reports and documents from NGOs and humanitarian agencies) and articles in the news media. The search strategy used broad search terms to include any relevant sources with reference to the contextual, social, economic, cultural, mental health, and health related factors among Rohingya refugees living in the Asia-Pacific and other resettlement regions (see Flowchart 1 below).

In the first step, the lead author formulated a comprehensive work plan which engaged expert reviewers, volunteer students, and research

Flow Chart 1. Overview of the desk review process

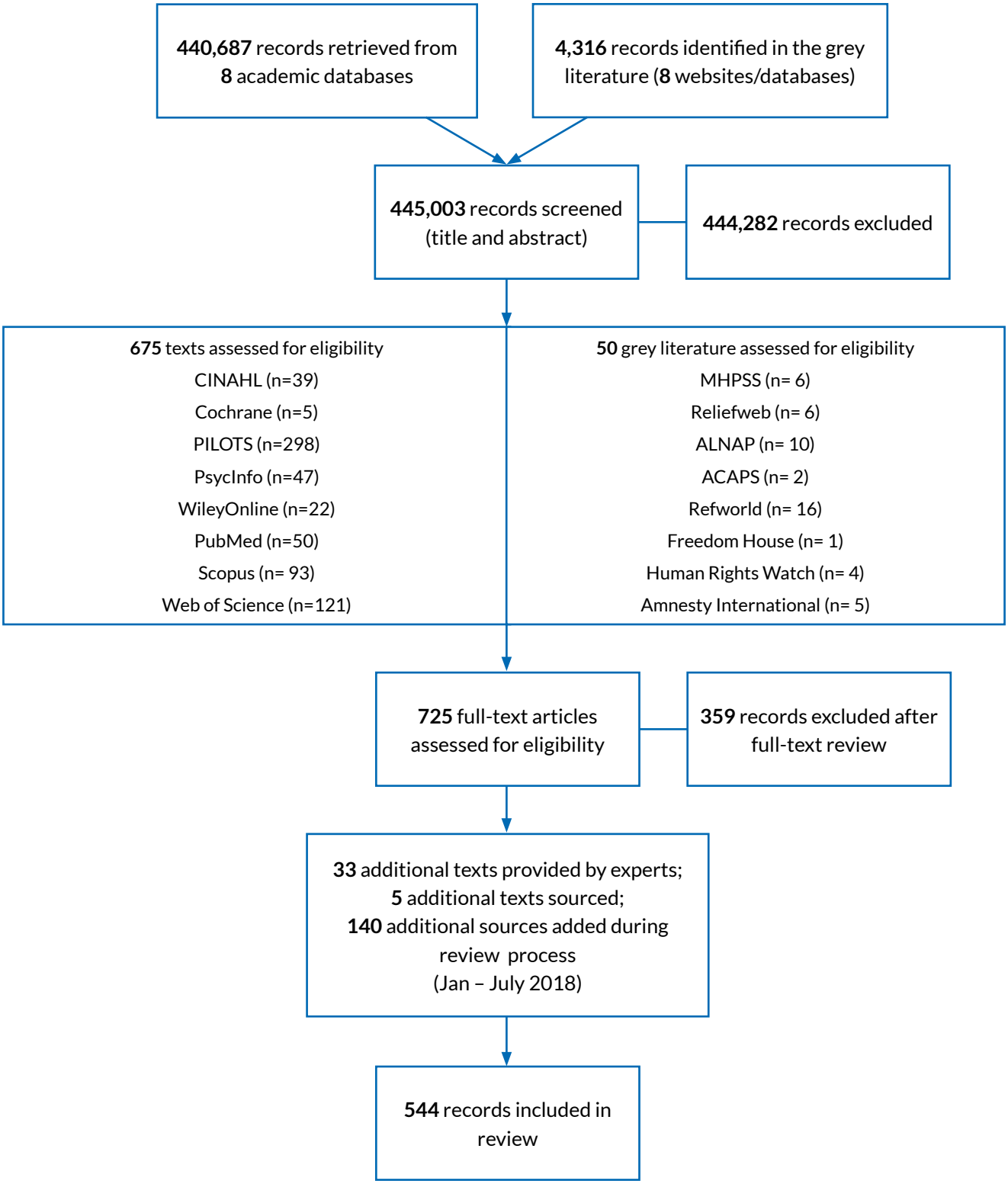


assistants from Australia, the UK, and the USA. The editorial team included the lead author (a researcher and clinician from Australia), the UNHCR senior mental health officer, and other academics from the University of New South Wales (UNSW) in Australia and the University of Denver in the United States. The editorial assistant team and contributor team comprised a research assistant from UNSW and nine Master's Degree students from the London School of Hygiene and Tropical Medicine (LSHTM) and the University of Denver, selected based on their qualifications and experiences in a wide range of disciplines including Medicine, Public Health, Mental Health, Psychology, International Relations, Anthropology, and Cultural Studies. An expert review committee included a multidisciplinary team from various backgrounds (e.g. Anthropology, Psychiatry, Psychology, International Relations) and were selected based on recommendations and relevant prior experiences working with Rohingya.

The search terms used, provided in Appendix 1, were organized in a structured string format. The online databases were selected with the intention of sourcing peer-reviewed texts from a diverse range of disciplines including Anthropology, Ethno-cultural Studies, Psychology and Public Health. The websites used to collect grey literature were identified from previous UNHCR desk reviews. Flow Chart 1 outlines the steps involved in the literature search, screening processes and review procedure.

In the second step, the research assistant conducted the literature search over the period 23–25 October 2017, under the supervision of the lead author. The third step involved the delegation of tasks to student assistants, whereby the database reference lists were distributed for screening and then full-text review. Each text was screened for either inclusion or exclusion based on the criteria specified. The students compiled draft sections (third step) that were assessed independently by the research assistant and the lead author who together resolved any discrepancies (fourth step). In the fifth step, the assistants and the lead author undertook the writing of the sub-sections and compiled them into a single first draft report. In step six, a group of eight experts reviewed the first draft, provided comments and added additional literature. Step seven consisted of an extensive and rigorous editorial process by the author and the senior mental health officer, resulting in a second draft. In step eight, the text was sent out to the core group of experts plus 40 other experts from UN agencies, NGOs and individual experts. Based on the reviews and the additional literature, a fully revised third draft was compiled (step nine) that was circulated among a targeted group of experts for further input and review (step ten). Step eleven consisted of drafting a pre-final version that was that was subsequently edited, formatted and released.

Flow chart 2. Literature search flow chart



2. CONTEXT

2.1 Myanmar: Geographical and demographic aspects

Myanmar, in the past known as Burma, is a country located in South-East Asia and bordered by Bangladesh and India to the west, China to the northeast, Laos to the east and Thailand to the southeast. The southern half of the country reaches the Andaman Sea and Bay of Bengal. The country's largest city and former capital Yangon is situated in the southern delta region of Myanmar. Naypyidaw, a newly-constructed city located to the north of Yangon, was officially declared to be Myanmar's new capital in 2006.

The population of Myanmar comprises approximately 51 million persons with nearly 30% of the population living in urban areas [6, 7]. It is an ethnically and religiously diverse country, with 135 officially recognized and recorded ethnic groups as well as several other ethnic groups, such as the Rohingya, that are not officially recognized. The majority ethnic group are the Bamar, who constitute about two thirds of the population, and who dominate the military and government. Myanmar has seven regions (or divisions) that are largely inhabited by the Bamar [8]. Additionally, there are seven states, named after the ethnic minorities residing in that state: Chin, Kachin, Karen, Kayah, Mon, Rakhine, and Shan [8, 9]. The regions and states are divided into 74 districts and sub-divided into 413 townships [7].

Rakhine State has five districts and 17 townships [10]. It is one of the poorest states in Myanmar with an estimated 78% of the population living in extreme poverty [11, 12]. The largest ethnic groups in Rakhine State are the Buddhist Rakhine and the Muslim Rohingya. A smaller Muslim group in Rakhine State are the Kaman, who are recognized as citizens by the government [10, 13, 14].

Until recently, Rakhine State was home to around 1.2 million Rohingya, comprising around approximately 40% of the total state population [15]. Accurately estimating the Rohingya population is difficult because they are excluded from census data by the government [16, 17]. Roughly two-thirds of the Rohingya resided in three northern townships of the state: Maungdaw, Buthidaung, and Rathedaung (Yethedaung) [18]. Rohingya were the majority ethnic group in Maungdaw and Buthidaung, the only townships in Myanmar with a majority Muslim population.

2.2 The Rohingya of Myanmar: A history of persecution and human rights violations

In the eighth century, people living in the coastal areas of the Bay of Bengal in what is currently called Bangladesh and Myanmar, converted to Islam under the influence of Arab traders [19, 20]. The Rohingya trace their history to that period [21, 22]. The Muslims in Rakhine State strongly self-identify as Rohingya but this term is not used as an indicator of an ethnic group in government documents and in Myanmar the term is controversial [12, 20, 23]. The government of Myanmar does not view Rohingya as *taingyintha* ('natives of the soil') [24] but considers them to be descendants of Bengal migrants who migrated during British colonial rule in the 19th and 20th century from more northern coastal areas, in what is now Bangladesh [25, 26]. Discussions about the ethno-history of the Rohingya and the origins of the term Rohingya have become highly polarized and sensitive [21, 27, 28].

Hostile attitudes towards the Rohingya fuelled a long history of systematic violence and discrimination, although there have been relatively better times: In the period from independence (1948) till the military coup (1962), Rohingya had full citizenship rights, and could serve in Parliament [17, 29]. During the military rule, their situation worsened and their civil, political, educational and economic rights were gradually stripped away [30]. The 1982 Citizenship Act enforced the exclusion of the Rohingya people from the list of officially recognized minority ethnic groups and denied them many basic rights including citizenship, freedom of movement, access to healthcare and education, marital registration rights and voting rights [31]. This effectively rendered them

the largest stateless group in the world. In spite of a series of political and economic reforms in the last decade led by former President Thein Sein, violence and discrimination against ethnic minority groups continued, although Rohingya were allowed to vote and serve in Parliament in the 2010 general election. Anti-Muslim sentiments have been provoked by Buddhist extremist groups who have created public support for systematic campaigns of violence and discrimination against Rohingya [22, 32]. While previously the ethnic groups in Rakhine State had a history of positive community relationships and close mutual dependency, relations between the Rohingya and other ethnic groups have become increasingly complex and sensitive since 2012 [21, 22, 32]. All people in Rakhine face difficulties in meeting basic needs, but the Rohingya and other Muslim communities, face particular challenges, related to discrimination and the lack of citizenship [33].

Restrictions against Rohingya are manifold. They are not allowed to form organizations or vote. They face major challenges in accessing education in general, and particularly university education. They often experience extortion (when going through check points, when marrying, having children, when building a new home, when repairing a home) and may have their names arbitrarily changed by officials creating the official family lists. Rohingya are not allowed to build homes with permanent materials like concrete, and at times were not allowed to install fencing around their homes. Mosques have been closed or destroyed [21, 34–37].

In October 2016, an armed group of Rohingya insurgents calling themselves Harakah al-Yaqin (Faith Movement) attacked Border Guard Police bases in the northern townships of Rakhine State. The government reacted with military force that the International Crisis Group said failed to adequately distinguish militants from civilians and stepped up the process of further restricting humanitarian assistance to Rohingya [38]. Based on interviews with refugees who fled to Bangladesh after the eruption of violence in 2016, the Office of the High Commissioner for Human Rights and Amnesty International documented a wide range of human rights violations against the Rohingya population in Rakhine State including killings, disappearances, torture and other inhumane treatment, rape and other forms of sexual violence and arbitrary detention [37, 39].

In August 2017, the same insurgent group, now under the name Arakan Rohingya Salvation Army (ARSA), carried out attacks against police posts in northern Rakhine State. According to reports by the Independent International Fact-Finding Mission on Myanmar, the International Crisis Group, Amnesty International and investigative reporters, these incidents were followed by a massive clearance operation by the Myanmar army, during which Rohingya homes and villages were systematically burnt down and thousands were killed by violence [40–44]. These events prompted an unprecedented exodus of Rohingya to neighbouring Bangladesh [45, 46].

A brief overview of historical events in Myanmar/ Burma is provided in Appendix 2

2.3 Rohingya refugees

The oppression of the Rohingya people resulted in repeated population movements within Myanmar and to other countries, culminating in the mass displacement of Rohingya to Bangladesh in the second half of 2017. It is unclear how many Rohingya remain in Myanmar. At least 120,000 Rohingya in the central part of Rakhine State in Myanmar remain in camps for Internally Displaced People (IDPs) in overcrowded shelters and under generally poor conditions [34, 47]. Due to lack of access, the UN agencies have not been able to independently verify numbers of Rohingya left in Rakhine State or displaced within Myanmar [34].

Over the years, many Rohingya have fled to neighbouring countries including Bangladesh and Malaysia. A substantial number have also sought refuge in Saudi Arabia, Pakistan, India, and small numbers are found in Nepal, Thailand and Indonesia [1, 48, 49]. None of these countries is party to the 1951 Refugee Convention or 1967 Protocol, which poses challenges to efforts to provide international protection for Rohingya refugees. A minority of Rohingya have been resettled in high-income countries such as the United States, Canada, United Kingdom and Australia.

Table 1. Period of arrival of Rohingya refugees in Cox's Bazar Bangladesh [54]

Arrival period	Number of persons	% of total
Before 9 Oct 2016	72,821	8%
Between 9 Oct 2016 and 24 Aug 2017	93,645	11%
Between 25 Aug 2017 and 31 Dec 2017	712,179	80%
Jan 2018 to current	13,223	1%

Table 2: protection vulnerabilities among Rohingya refugees in Cox's Bazar Bangladesh [54]

Protection concern	Percentage of families
Single mother	16%
Serious medical conditions	5%
Older persons at risk	4%
Disability	4%
Separated child	2%
Older person with children	2%
Unaccompanied child	1%
Single male parent with infant	1%

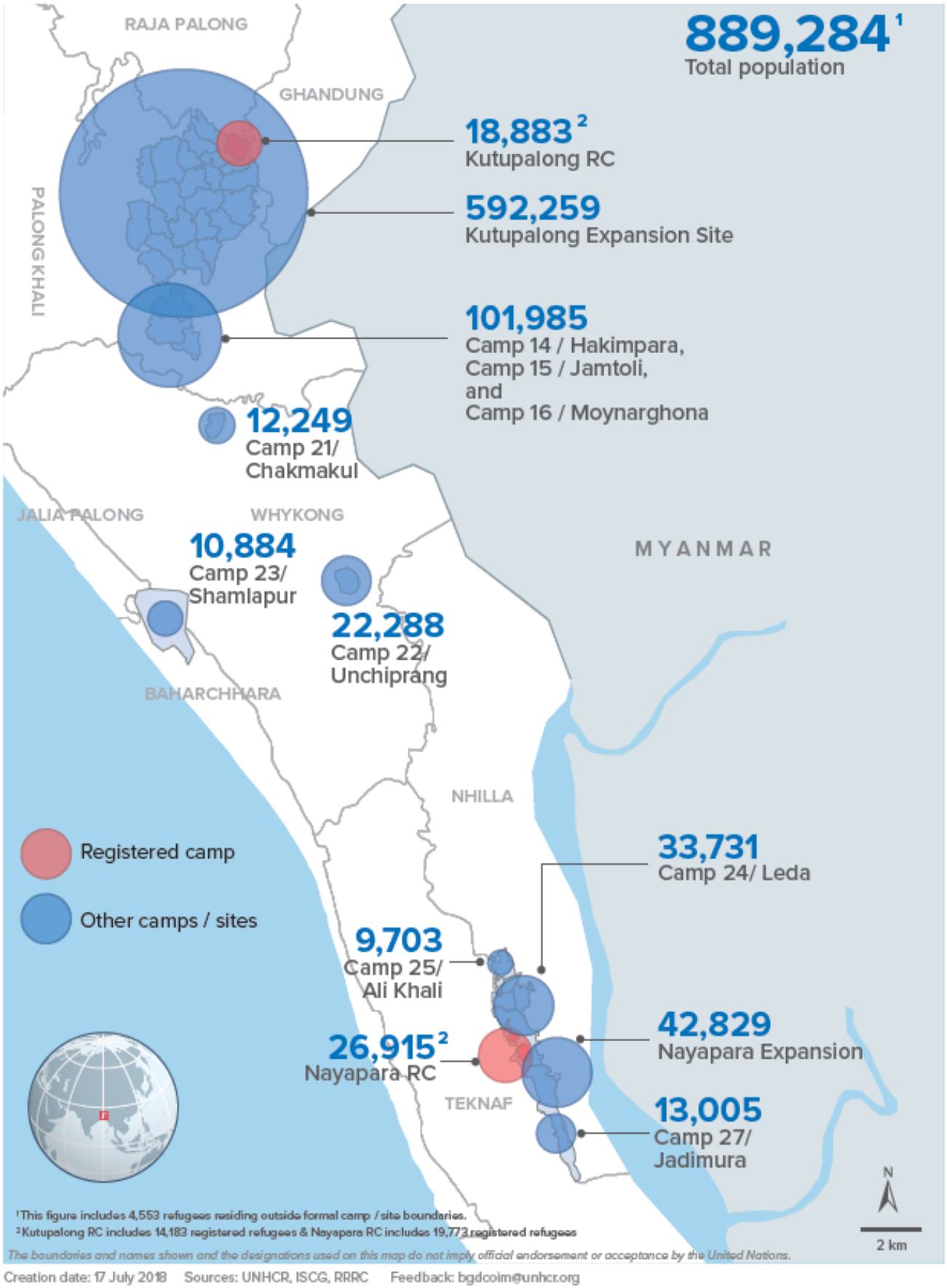
Rohingya refugees in Bangladesh

Bangladesh has a long history of hosting Rohingya from Rakhine State in Myanmar. The Cox's Bazar district in the Chittagong Division borders the northern part of Rakhine. This district received large numbers of Rohingya refugees in 1978 (around 250,000 people) most of whom returned to Myanmar after international pressure on the Myanmar government to allow them to return [50]. Another large wave of Rohingya refugees arrived in Bangladesh in 1991–1992 when again around 250,000 people crossed the border [2, 51]. They were recognised by the Government of Bangladesh (GoB) as refugees and hosted in camps in the Cox's Bazar district. After several years, the Bangladeshi authorities enforced a policy of repatriation of the refugees. Living conditions in the camps deteriorated which forced most of the refugees to return to Myanmar [52]. Some of the Rohingya who arrived in 1991 and 1992 remained in two camps (Kutupalong 'registered camp' and Nayapara 'registered camp'). Until 2017, these camps were home to around 32,000 registered refugees. The camps still exist but they have now become part of much larger refugee sites accommodating more recently arrived refugees.

Many more Rohingya, who arrived after 1992, were not recognized as refugees by the Bangladesh authorities and lived in poor conditions in 'refugee-like situations' in makeshift camps surrounding the official camps and Shamlapur at the coast [53]. These unrecognized refugees were not allowed to receive the services that UNHCR and its partners provided to registered refugees. After the crisis of October 2016 in Rakhine State, an additional 70,000 Rohingya fled to Bangladesh. The Government of Bangladesh allowed them to cross the borders unimpededly and the Bangladesh community responded with an outpouring of private assistance. Without waiting for GOB authorization, the refugees further expanded the makeshift settlements around the registered camps and also established an entirely new area of makeshift settlements in Balukhali (in what is now called Camp 10 in Kutupalong).

The mass influx of 712,179 refugees from 25 August to 31 December 2017 and an additional 13,223 who arrived since January 2018, caused a major humanitarian emergency that gravely compounded the existing challenges around the provision of assistance to the estimated 200,000 to 300,000 Rohingya refugees who were already in Bangladesh. On 31 August 2018, UNHCR estimated that 889,753 Rohingya refugees were in need of assistance in

Map 1: Myanmar and its neighbours



Cox's Bazar District [54]. See table 1 for details of the current Rohingya refugee population in Bangladesh.

Two thirds of the refugees in Bangladesh originate from Maungdaw township in the northern part of Rakhine State. Thirty one percent of the refugee families have been identified as having at least one protection vulnerability. See table 2.

The arrival of so many refugees to the South-eastern districts of Bangladesh has caused a significant increase in population in Cox's Bazar district: in the sub-districts of Teknaf, the Rohingya refugees form 29% of the total population and in Ukhia (which hosts the very large Kutupalong refugee settlement) they form an estimated 76% of the total population. Most Rohingya live in camps, but an estimated 79,000 live among the Bangladeshi host communities [55]. The considerable growth of the refugee population in Ukhia and Teknaf has seriously impacted the Bangladeshi host communities due to deforestation, inflation, and competition for labour opportunities, [4, 56]. While segments of the host community, such as medium size and small traders, benefit economically from the presence of refugees, other sectors of the local communities feel neglected in relation to the aid provided by humanitarian agencies, leading to reported tensions between the Rohingya and Bangladeshi communities [55].

Rohingya refugees in Malaysia

Currently, there are over 70,000 Rohingya refugees registered with UNHCR Malaysia and an estimated 30,000–40,000 more who remain unregistered. The Rohingya came in waves with the highest numbers of arrivals in the period 1990–1994, 2000–2004 and 2012–2015. In the period from 2012 to 2015, many arrived by boat in Thailand after undertaking dangerous journeys across the Andaman Sea prior to being smuggled or trafficked into Malaysia [1, 57]. Rohingya live throughout Peninsular Malaysia, all being considered 'illegal' or 'prohibited' immigrants under the Immigration Act and therefore are at risk of arrest [58, 59]. The Rohingya in Malaysia live in overcrowded housing with lack of access to educational opportunities, employment, and healthcare [60, 61]. Some Rohingya have lived for decades in Malaysia and have established livelihoods and/or are in receipt of remittances from relatives resettled in Australia, Canada, Denmark, or Sweden [62] but many continue to live in precarious economic situations [63].Those who have been detained in immigration detention centres are at risk of indefinite confinement, malnutrition, physical and mental abuse and assault, exploitation and extortion [64, 65].

Rohingya refugees in Thailand

The UNHCR currently assists around 100 Rohingya refugees in Thailand who are confined to shelters or kept in detention centres. A few thousand more live in the community throughout Thailand [66]. Southern Thailand is a transit point to Malaysia [66] which has attracted smugglers and traffickers taking Rohingya to Malaysia. Rohingya have experienced severe abuses at the hands of the smugglers and traffickers, and in 2015, mass graves were discovered with what are believed to be Rohingya remains in southern Thailand [67, 68].

Rohingya refugees in India

As of April, 2018 around 17,705 Rohingya refugees are registered with UNHCR in India, in addition to an unknown number who remain unregistered.[1] Rohingya live across different urban/semi-urban locations in the country. They often live in impoverished slum-like settings [69, 70] in poor sanitary conditions with limited access to water and toilets [71, 72]. In principle, all refugees in India have access to government health and education services, but at times they have difficulties in accessing these facilities. UNHCR supports them to the extent possible through governmental/non-governmental agencies and partners. Most Rohingya refugees in India lack skills and are poor, only being able to find low skilled jobs in the informal sector (which also employs a large majority of Indians).

[1] Information obtained through UNHCR in India

Rohingya in Saudi Arabia and other countries on the Arabian Peninsula

There are approximately 250,000 documented and an unknown number of undocumented Rohingya in the Kingdom of Saudi Arabia. Most came to the country in different waves since 1960. The majority are believed to have entered the country without documents or on Pakistani, Bangladeshi, Nepali, and Indian passports that expired during their stay. Saudi Arabia is not a state party to the 1951 Convention and does not have a national legal structure supporting asylum. Deemed to be a persecuted group on religious grounds, a Royal Decree made an exception to allow the Rohingya to obtain four-year residency visas (known as an *iqama*) to ensure access to education, the labour market, and health services. This process of regularization and documentation of Rohingya applies only to those who entered Saudi Arabia before 2008. Individuals who entered the country after that date cannot benefit from these provisions.[2]

Other states on the Arabian Peninsula, such as the United Arab Emirates, also house significant numbers of Rohingya but the exact figures are not known [3, 73].

2.4 Rohingya and religion

Rohingya are the predominant adherents of Islam in Myanmar, practicing a conservative form of Sunni Islam, based on the Hanafi *mazhab* (school of thought) [63] and that according to some observers has become more orthodox under influence of movements such as the *Tablighi Jamaat* [74]. Religious identity remains important to Rohingya refugees [49, 75]. For example, in a randomly selected sample of 30 Rohingya in Gombak, Malaysia, all concurred that faith in God helped them in difficult times and that religious beliefs were vital to the way they lived their life.[3]

Older men grow beards and the women usually wear the *hijab* (veil covering the head and chest) [76]. Women are restricted from participating in some parts of public and civic life. The traditional houses are surrounded by fences of bamboo, which enables the practice of *purdah* (strict gender segregation) preventing women to be seen by outsiders.

There used to be mosques and *madrasahs* (religious schools) in every Rohingya settlement. Men visited the mosque to pray together, while women prayed at home. A governmental ban in 2012 on gatherings of more than four people in Muslim-majority areas made it difficult for Rohingya to pray together. Traditionally, Rohingya have mechanisms to maintain a strong sense of solidarity and collectivism in the villages, a tradition called *samaj*. Practices include communal meat distribution during the religious festival of Eid, and support arrangements for orphans and widows [76]. Rohingya also generally make the obligatory Muslim donation (*zakat*) to the needy in the community. Like other Muslims, Rohingya celebrate the Islamic holidays including *Eid al-Fitr* ('feast of breaking the fast'), *Lailat al-Barat* ('night of salvation'), *Lailat al-Qadr* ('night of decree') and *Eid al-Adha* ('feast of the sacrifice').

Historically, *mullahs* (Islamic theologians), *moulvis* (qualified Islamic teachers), and elders played important roles in Rohingya villages in Rakhine State [75]. Government restrictions on Rohingya community life in Myanmar have greatly diminished these roles over the past 20 years.

Highly respected in the community are the *háfes*, persons who have memorized the Quran. They are often descendants of prominent religious figures, *Háfes* are usually men, but women can also become *háfes*, even though this is rare. Female *háfes* are often consulted by other women for guidance on personal matters, such as how to deal with the husband and may give informal religious classes to small groups of girls or women [74].

While the vast majority of refugees from Rakhine State are Muslim, a small percentage are Hindu [77]. In Rakhine State there were around 21,000 Hindu who are not recognized as an official ethnic group in Myanmar [23]. They speak the same dialect as the Rohingya but usually do not self-identify as Rohingya. Reportedly, there are tensions arose between the two communities in Rahkine in 2017 following Rohingya attacks. On their request, a few hundred Hindu refugees were accommodated in separate refugee settlements in Bangladesh [78, 79].

[2] Information obtained through UNHCR in Saudi Arabia

[3] Information obtained through C. Welton-Mitchell (May 4th 2018).

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2.5 Gender and family aspects

Gender roles and family dynamics

Polygamy, although prohibited by the Myanmar government, remains a traditional practice in the Rohingya culture. The Rohingya typically live in extended families with men heading the household, although women and girls may assume the head-of-household role in the absence of a male [80]. Many Rohingya women and children in Bangladesh live in extremely vulnerable conditions of insecurity as they lost or became separated from their husbands and fathers while fleeing for their lives. Marriage continues to be the primary means of attaining social and economic security for Rohingya women and girls, who are traditionally discouraged from working [75, 81]. The responsibilities of women and girls include all aspects of childcare, food preparation, cleaning, laundry, and caring for the elderly.

Both nuclear and extended family structures are observed in camps for displaced persons in Bangladesh [80]. There are also single mothers, single fathers, and children living with extended family members who are not their biological parents [80].

The practice of *purdah* is widespread in Maungdaw and Buthidaung townships. While girls up to the age of 12 years are commonly seen outdoors in the villages, frequently caring for younger siblings, at the point of puberty, girls often are required to remain within the family home until marriage, and often even following that milestone. The *burqa* and *niqab* (sometimes in combination with an umbrella, for additional modesty) offer increased mobility for women who otherwise would face even greater scrutiny and harassment for conducting their normal business out of doors. Some women, particularly those who have had greater access to education, and as well those who are heads of households, seek work outside the home. Employed women frequently face admonition from their communities and accusations against their character. The perceived 'failure' to adhere to cultural restrictions curtailing women's liberty of movement is seen to reflect poorly on the social status of their families.

The power of women within the home is not uniform as it varies with age and status. When Rohingya women marry, they leave their family and are considered part of their husband's family from that point onward. They join the husband's household and are under the supervision and control of the

mother-in-law. According to a traditional hierarchy, the wife of the eldest son of a family has relatively greater influence within the household than the wife of the next son, and so on. Decisions related to children's health are traditionally made by the most powerful woman within the household. Marriage is accompanied by a 'dowry': a gift by the family of the bride to the family of the groom. Among the Rohingya in Rakhine State the dowry varies according to the bride's family resources, extending from a simple pair of gold earrings to large amounts of money, or land. The practice of dowry can be a major source of conflict in the household, including between the husband and wife, but particularly between the bride and her mother-in-law, a factor that contributes to risk of domestic violence against the wife/bride [82].

One of the few acceptable reasons for a woman to leave the home amongst Rohingya in Myanmar is to access health services, particularly for children, although approval is still required from the husband or head of household. Respected women in the community provide antenatal and postnatal care, consult with women on pregnancy and fertility concerns, and act as traditional birth attendants, overseeing labour and delivery [83, 84]. These services traditionally are provided free of charge, although attendants often receive symbolic gifts of food and clothing. However, as movement restrictions were intensified on the Rohingya, many traditional birth attendants either ceased providing services, particularly during the night, or began charging fees.[4]

Sexual and gender-based violence

Rohingya women and girls are frequently subjected to multiple forms of abuse including harassment, economic deprivations and psychological and physical violence. High rates of exposure to sexual and gender-based violence (SGBV) have been reported by a range of humanitarian agencies and human rights organizations amongst Rohingya communities in Myanmar and countries of displacement. Nevertheless, accurate documentation of SGBV remains a challenge given the stigma and fear of retaliation if these abuses are reported by female survivors [85, 86]. The potential social impact of rape is far-reaching. If it is suspected that a woman had been raped, she may be ostracized by the community and her family, and at times husbands may disavow wives, even on suspicion that the wife has been subjected to this form of SGBV [52]. For girl survivors of rape, the chances of marriage are much diminished, particularly of finding a 'good husband'.

Within Rakhine state, SGBV against Rohingya women has been documented via testimonies of refugee women arriving in Bangladesh in 2017. They recounted multiple forms of violations including harassment, sexual molestation, forced prostitution, and rape by Myanmar military soldiers and members of the other ethnic groups in the Rakhine state [86–89].

Outside Myanmar, among Rohingya refugees, SGBV remains a major protection concern. In the longstanding camps for registered Rohingya refugees in Bangladesh, SGBV was reportedly widespread [52]. In 2013, 12.8% of respondents in a random household survey (n=148) reported exposure to sexual abuse, humiliation, or exploitation (e.g., coerced sexual favours) and 8.1% said they had been exposed to rape (forced, unwanted sex with a stranger, acquaintance, or family member) [90]. Collecting firewood around the camps was a high-risk activity for rape and kidnapping, sometimes involving 'block leaders' known as the *majhi* [51].

In the refugee settlements in Bangladesh that were established in the second part of 2017, SGBV is a serious problem [88, 91]. A joint report in the early stages of the humanitarian response in Cox's Bazar highlighted several concerns around prevailing practices for SGBV survivors, including limited privacy and safety issues for women survivors living in shelters (safe houses for women), a lack of gender-segregated latrines and washing facilities, and the risk of retaliation against female survivors by family members and members of the community [92]. The general living conditions of the refugee settlements in Bangladesh are conducive to various forms of SGBV, including exploitation and increased intimate partner violence, which expose both men and women to protection risks.

[4] Information provided by MHPSS worker in Myanmar who wishes to remain unnamed.

Women who were trafficked or smuggled to third countries reported rape and exploitation by smugglers and traffickers [93]. There are indications that refugee women and girls are being trafficked or smuggled from the large refugee settlements in the Cox's Bazar district to cities in Bangladesh and other countries to work in the sex industry [94–96].

SGBV is not only committed by outsiders. In the refugee settlements in Bangladesh prior to the crisis in 2017, experiences of intimate partner violence were abundant, and often related to the economic disempowerment of Rohingya men who were not allowed to work and grew increasingly frustrated [97]. Organizations working on sexual and gender-based violence prevention and response in the refugee settlements in Bangladesh are reporting increased violence among polygamous families. In Malaysia, Rohingya women reported high levels of intimate partner violence, with the vast majority indicating that their partner had pushed, shoved, or slapped them in the last year, and over half reporting that their partner had punched, kicked or beat them up in the last year [98].

Child marriage (involving persons under 18) is another form of SGBV that is common among Rohingya communities [99, 100]. Girls and women generally marry at an early age and have limited access to educational opportunities, knowledge about reproductive health, and influence over family planning [101]. Married underage girls are at increased risk of a range of physical and psychological consequences including intimate partner violence.

Men and boys also report SGBV incidents. During focus group discussions, rape and genital mutilation was reported to have happened among men in Myanmar and men were reportedly forced to witness the rape of their wives or other members of their families.[5]

Appendix 7 presents a list of common Rohingya terms for gender and intimate partner violence.

2.6 Customs and language

Clothing

Rohingya women typically dress in traditional clothing, such as a *sarong* (also called *ta-mi*, *ta-ine*, or a female *longyi*) which is a large cut of fabric, often wrapped around the waist. Men often dress in *longyi* (a sheet of cloth wrapped around the waist extending to the feet that is widely worn in Myanmar). Rohingya women wear a *hijab* (head covering veil) or a *niqab* (face covering veil) [102, 103]. Many Rohingya use the term *burqa* to refer to a black dress/robe worn over the *longyi* and blouse. Women wear this outside their house or place of work, but there are important regional differences. Due to remoteness and restrictions on movement, Rohingya in rural areas in the northern townships of Rakhine State tend to be more conservative than those in the central townships (i.e. Sittwe, Pauk Taw, Min Bya, Mrauk Oo and Kyauk Taw) which are more urbanized and where people have easier access to higher levels of education. In the central townships, women do not necessarily wear the full *hijab* while women in the northern townships of Rakhine may, in addition to the *hijab*, also wear a *burqa* and *niqab*. Several humanitarian workers observed that this custom has changed rapidly since the encampment of internally displaced persons in 2012 in that there is an increase of conservative values within the groups now confined within the camps for internally displaced persons in Myanmar. Within refugee settings in Bangladesh, some humanitarian workers report an increase in the use of face-covering clothing.

As part of their traditional cultural practice, Rohingya women decorate their skin with henna paste, or '*mehendi*' for marriage or religious ceremonies. Women and girls also use sandal wood powder on their face. Older men use henna to colour their beards as a religious practice [104]. *Henna* may also be used as traditional medicine to heal broken bones, headache, backache, stomach pain or burns [104].

[5] Focus groups discussions facilitated by the UNHCR Bangladesh, in Cox's Bazar, in June and July 2018

Food

The common Rohingya diet consists of rice, fresh and dried fish, potatoes, vegetables, rice noodles, chicken, milk and chillies. Occasionally, for example at religious holidays, people eat meat (beef, mutton and chicken) slaughtered according to the Islamic law (halal). Islamic law prohibits consumption of tortoise, crab and pork. If they can afford it Rohingya use three meals per day. The family usually has the meal in the house, men and children taking their meal first with the women and older girls taking their meal after the men have finished.

For recreational purposes, people widely use betel leaf (*paan*) with areca nut and tobacco. After chewing it is either spat out or swallowed. When people meet each other or make a home visit, they habitually offer *paan* (betel leaf) and areca nut. Many men smoke, either cigarettes or *biri* (handmade cigarette). Some women also smoke. Use of alcohol is prohibited by Islamic law.[6]

There are significant dietary restrictions around pregnancy and particularly during the lactation period. Many Rohingya believe that pregnant women should not eat beef and not have contact with cold water, particularly rain water and should drink only hot water/tea. During 40 days after giving birth a woman eats mainly plain rice and chillies and if the family can afford it, dried fish. Dry food, particularly dried chillies, are thought to fasten the mothers' recovery. Vegetables and beans are prohibited during this period. In fact, there are many dietary restriction for women in the six months after giving birth. These restrictions vary between families and communities and are to a large extent idiosyncratic. Forbidden food times may include 'fish with navel', shrimps, meat (particularly goat meat), certain fruits (such as coconut and pineapple) and vegetables (such as eggplant and fresh beans [74, 82]. Children are usually breastfed till the age of two years [105].

Names

Rohingya do not have surnames and names do not change when individuals get married. The use of names is dictated by custom, for example, it is cultural practice that younger persons do not address older persons by their name, but according to their age, gender, and position in the family and society. In Myanmar, particularly in central Rakhine, Rohingya may have two names, one Muslim and one Burmese [106]. Rohingya often abbreviate names: for example, Mohamed will be pronounced as 'Mammad', Hussein as 'Hussaun' or 'Hussinya', Ahmed as 'Ammad', Mohamed Ullah as 'Madullah' and Hafiz as 'Habes'.

Language

The Rohingya language (Ruáingga or Rohingya) is an Indo-Aryan language that is closely related to the Chittagonian (Chittagong) dialect of Bengali (Bangla) which is spoken by the Bangladeshi host population around Cox's Bazar. The Rohingya language is primarily an oral language and does not have a standardized and internationally recognized written script. Various scripts are used to capture the Rohingya language in written form: Arabic, Urdu, Rohingyalish (a simplified Rohingya script using Latin letters), and Hanifi that is named after its developer Maulana Mohammed Hanif. The Rohingya language may also be transliterated at times using the Burmese alphabet, but even native speakers who are fluent in Burmese and English still struggle to read Rohingya in this form. Many Rohingya have low levels of education and even those who can read and write continue to face challenges in reading and writing Ruáingga due to inconsistencies and differences between different language systems [107].

Music and poetry

There is an oral tradition among the Rohingya that is expressed through poems and songs. *Tarana* poems/ songs express emotions (often related to despair, melancholy and fear). They can be recited or sung, sometimes with aid of musical instruments such as the *tobla* (small drums) or *juri* (traditional guitar-like instrument) Songs constitute a medium to keep alive the history and preserve the collective identity [102, 108].

[6] Personal communication A.N.M. Mahmudul Alam (UNHCR, Bangladesh), 5 August 2018.

2.7 General health aspects

Health care in Rakhine State

Within Myanmar, Rakhine State has less developed healthcare compared to the other states. Access and utilization of health services is made difficult for Rohingya because of their statelessness and severe restrictions in their movements [35]. They have restricted access to pursue university education in Myanmar and consequently, government and NGO health facilities within Rakhine State are staffed by national medical staff of other ethnicities, often from other parts of the country, serving one-year assignments in Rakhine State at the commencement of their medical careers. Restricted access to formal health services including public hospitals and government clinics as a result of long-standing discrimination and travel restrictions may account for the poor health outcomes observed among Rohingya refugees [35, 109]. Rohingya often seek out alternative traditional practices such as homemade medicinal remedies, or seek advice from traditional healers, herbalists, shopkeepers (who provide medicines and medical advice), and faith or religious healers [75].

Health care for refugees in Bangladesh

Health services for Rohingya refugees and the surrounding host community are provided by more than 100 different entities including the Government of Bangladesh, United Nations agencies and national and international nongovernmental organisations. In total, they operate 170 basic health units (1: 7,647 people in need); 33 primary health centres (1:39,394 people in need) and 10 secondary care facilities (1:130,000 people in need). Cox's Bazar has around 910 hospital beds, 290 in Government run facilities and others in private facilities or in temporary hospitals that have been set up as part of the humanitarian response [110]. Since the start of the crisis in August 2017 until 21 June, 2018, the health facilities have provided more than 2 million health consultations to the refugees and host populations [111].

Within the refugee settlements there is a geographical division for the coordination of health care services between IOM and UNHCR, each covering different zones with their partners. In response to health issues that have arisen from the humanitarian emergency, a Strategic Advisory Group for Health was established by WHO and the Ministry of Health and Family Welfare (MOHFW) of Bangladesh, comprising of United Nations agencies and major NGOs [112].

Acute respiratory infections, fever of unexplained origin, and acute watery diarrhoea were the most widely reported health conditions [110]. Amongst children under 5 years, diarrhoea, acute respiratory infections and measles represent a high disease burden with low coverage of vaccination (for measles) [43, 110, 113]. Rohingya children are reported to be at greater risk of diarrheal diseases compared to Bangladeshi children [114].

Low vaccination coverage, in addition to overcrowded living conditions, malnutrition, and inadequate water and sanitation, can precipitate disease outbreaks [115]. These risks are compounded during rainy season (approximately June – October) for which a massive preparedness and response plan was set up by the various humanitarian agencies in Cox's Bazar [116–118]. While the provision of reproductive and sexual health care in the refugee settlements in Bangladesh is improving, access to these services remains a point of concern [119, 120].

In December 2017, a diphtheria outbreak in the refugee camps of Kutupalong was reported. The WHO and the government of Bangladesh set up an Early Warning Alert and Response System (EWARS) for surveillance of communicable diseases [110]. Large-scale vaccination campaigns are being conducted for cholera, polio, diphtheria, measles and rubella which has vastly increased the coverage [110, 121, 122].

In addition to the inadequacy of health services of sufficient quantity and quality for the population as a whole, special needs groups, for example, with disabilities, and older people face access challenges arising from discrimination and exclusion, and inaccessibility in a terrain with steep hills [123, 124].

Nutrition

Infants, children under five years, pregnant and lactating women and adolescent girls are the most vulnerable groups in need of nutritional care [125]. The prevalence of Global Acute Malnutrition (GAM) and Severe Acute Malnutrition (SAM) in Rakhine

State prior to the 2017 violence already exceeded the emergency nutrition thresholds of the WHO Crisis Classification [126, 127]. A Nutrition Assessment at one of the refugee settlements in Cox's Bazar showed that the prevalence of GAM was 24.3% while that of SAM, a strong predictor of mortality in children under 5 years old [128], has doubled to 7.5% from May to October 2017 [129, 130]. Although, according to the results of the most recent round of nutrition assessments in the camps in May 2018, the prevalence of acute malnutrition is decreasing, it remains unacceptably high and there are many aggravating factors such as high disease burden, poor WASH situation, shelter environment and the rainy season. Stunting or chronic malnutrition which is a marker of longer terms nutritional deficits is high at around 40% and anaemia which is used as a proxy amongst others of a micronutrient poor diet is elevated at over 30% – although there has been a reduction observed since October 2017 [131].

Infant and young child feeding practices among the Rohingya refugees in Bangladesh are poor with low levels of exclusive breastfeeding amongst infants under six months old and timely initiation of breastfeeding. This is possibly linked to the common practice in parts of Myanmar and Bangladesh, where a newborn is fed a sweet beverage (sweetened with sugar or honey) just after birth. In the assessment in May 2018, almost 70% of caregivers reported this practice. Minimum acceptable diet is an indicator that combines dietary diversity and meal frequency for children 6–23 months old and has been shown to be exceptionally poor in this population at 7.3% in the makeshift camps. An in-depth Infant and Young Child Feeding (IYCF) assessment is planned for the second half of 2018 to explore the practices in more detail in order to better tailor interventions for the prevention of malnutrition in young children.[7] Families with a malnourished child (*ganda*) may be reluctant to seek help out of shame as it may indicate that the family has not been able to care for the child [75].

[7] Information provided by C. Wilkinson, Senior Nutrition Officer, UNHCR, 6 August 2018


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3. MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING OF ROHINGYA

3.1 Epidemiological studies of mental disorders and risk/protective factors

While our initial search identified a significant body of mental health research among ethnic groups in Myanmar, there are few published reports that focus specifically on the mental health and psychosocial status of Rohingya. In our literature review (including unpublished reports from NGOs), we identified 33 documents of broad relevance to the mental health and psychosocial wellbeing of this group. Observations through qualitative research in Bangladesh and Malaysia in 2016 highlight a high sense of mistrust among Rohingya refugees and fear of exploitation by fellow Rohingya [132]. The table in Appendix 3 shows the estimated prevalence of mental health problems and associated protective/risk factors derived from these studies. Our review did not identify any systematic epidemiological studies of Rohingya, with the exception of a small cross-sectional study conducted amongst Rohingya living in Bangladesh [90]. Taken together, the available studies indicate high prevalence of a wide range of mental concerns including the endorsement of symptoms typically associated with posttraumatic stress disorder (PTSD) and depression. In addition, there is a high level of reporting of other mental health concerns including: explosive anger, psychotic-like symptoms, somatic or medically unexplained symptoms, impaired functioning, and suicidal ideation. Caution needs to be exercised in interpreting these results because measures have not been validated for the Rohingya population. Notably, wide variations in prevalence of mental disorders have been recorded across psychiatric epidemiological studies conducted with war-affected communities [133]. These variations may be a result of contextual influences, methodological issues, the use of different instruments, and time following conflict [134, 135]. There is a particularly high risk of

transcultural measurement error in relation to the use of standard self-report questionnaires. Future studies are needed to examine the nature and course of symptoms, for example, they may be normative and not interfere substantially with adaptation or they may become maladaptive/pathological with the passage of time.

See Appendix 3 for a table with an overview of Mental Health Epidemiology amongst the Rohingya Refugees

Studies among Rohingya refugees in Bangladesh before the 2017 humanitarian crisis

Over the years, various general assessments and observations concerning registered Rohingya refugees in the official camps in Bangladesh attested to the high level of psychological distress in this population. Noted were high levels of anxiety, in that refugees were on constant alert for danger; poor sleep; depressed mood; loss of appetite; suicidal tendencies; and high levels of unexplained medical symptoms [136]. High levels of emotional distress are attributed both to exposure to traumatic events in Myanmar and to the protracted nature of the refugee situation, with lack of durable solutions and conditions of daily living including constrained living arrangements, dependency on food assistance, obstacles to pursuing livelihoods and high levels of domestic violence [96, 132, 137, 138]. During a Joint Assessment Mission in 2016 by a team of the Government of Bangladesh, the World Food Program (WFP) and UNHCR, the poor mental health status of refugees was raised as an important issue, a point where the report noted that "many refugees became quite emotional regarding their vulnerable situation and lack of hope" [138].

We found four studies related to mental health among Rohingya refugees in Bangladesh in the period before the current emergency. Firstly, in 2006, MSF conducted a qualitative inquiry into the mental health and social situation in refugee settlements around Cox's Bazar. The report highlights high levels of anxiety, depression, fear, and lethargy, especially among women. In addition, symptoms of paranoia, hyper-alertness (in the men), as well as behavioural disturbances including feelings of helplessness and passivity were listed as potential contributors to functional impairment in refugees [139].

Secondly, a study was conducted in 2013 among 148 randomly selected Rohingya refugees (78 women, 70 men) living for long periods in the two registered refugee camps of Kutupalong and Nayapara [90]. This survey assessed exposure to potentially traumatic events, daily stressors, and mental health outcomes. Events occurring prior to flight included, in order of prevalence, destruction of property (75%), beatings (56%), extortion or robbery (55%), being forced into hiding (52%), interrogation by police authorities (50%), threats against self/family (49%) and torture (40%). Daily living difficulties included shortage of food (95%), restricted movement (82%), lack of access to basic services (78%), safety and protection issues (77%), lack of healthcare services (70%) and shelter (67%). Results indicated high levels of mental health concerns including symptoms indicative of PTSD (36%), depression (89%), and associated functional impairment. Participants also expressed local idioms of distress, including somatic complaints and concerns linked to spirit possession. While there was a direct effect of trauma exposure on mental health outcomes (PTSD symptoms), daily environmental stressors partially mediated this relationship. In addition, depression symptoms were associated with chronic stressors but not previous trauma exposure. The symptom rates for PTSD and depression in this study among Rohingya refugees confined to the camps in Bangladesh appear to be substantially higher than the pooled prevalence of 15% and 16% reported in a meta-analysis of all contemporary refugee and post-conflict mental health studies [135, 140].

Thirdly, in 2008, Action contre la Faim (ACF) did an assessment in the two registered camps (Kutupalong and Nayapara) with the 20 item Self Reporting Questionnaire (SRQ-20) among a community sample of 162 randomly selected women with at least one child under five years. Of the 20 symptoms, an average of 8.7 were endorsed, with 70.4% of the women endorsing at least five symptoms (which indicates the presence of significant psychological distress among the women in the camps [141].

Lastly, the same NGO (ACF) conducted a rapid assessment in late 2016 among 488 undocumented Rohingya, including children, living in makeshift settlements in the Cox's Bazar district with very limited access to humanitarian support. The stressors in this population were very high and were largely related to the restrictive humanitarian context with lack of space, lack of freedom of movement, and a

lack of access to basic services. While the study was not meant to provide prevalence figures of mental disorders, it was clear that the levels of emotional distress were very high, among children as well as adults. Frequently mentioned symptoms were sadness, low mood, lack of interest in daily activities, anxiety, and excessive anger and irritation [142]. See table 3 for details of this survey.

Data from UNHCR's health information system in the period before August 2017 showed that among the persons seeking help for mental or neurological problems, the most frequently diagnosed problems were psychosis, epilepsy and 'other psychological complaints' [143].

Table 3. Description of current stressors and MHPSS related distress among unregistered Rohingya refugees in Bangladesh in March 2017

Group	Current stressors (in Bangladesh)	Signs of MHPSS distress & issues
Children	Lack of space, no educational facility, lack of toys, dysfunctional family environment, lack of care	Crying, low mood, irritation, aggressive behaviour
Adolescents (boys)	Lack of freedom in movement, no playground, lack of clothing, poor relations among siblings, limited or no educational facilities, difficulties in making friends, poor socio-economic situation, safety and security tension	Excessive anger, poor appetite, substance abuse, crying, quarrelling, risky behaviours
Adolescents (girls)	Excessive heat/hot temperature, lack of clothing, lack of hygiene products, being married without parents' consent (reported by community), poor light and ventilation inside the houses, poor bathing conditions, lack of safety and gender-based violence	Lack of interest in daily activities, isolation, increased stress and anxiety, crying, anger, psychosomatic symptoms (such as, sleeping disturbance, lack of appetite), suicidal thoughts
Women	Scarcity of water sources, long distance to sanitation facilities from house, inadequate food, inability to feed children properly, not receiving money from husband, lack of freedom, lack of convenient house, fear of being abused at home and outside, long waiting time for any services, lack of space for socializing outside of their sheds	Passing most of the time in the house which results into limited social networking/ support, poor relation with husband, excessive anger, stress, stress linked to re-productive health related problems, expression of anger on children (eg. beating), stress outburst with elderly people, lack of interest in daily activities, feeling of hopelessness and suffocation
Men	Unemployment, having no independent work or workplace, lack of activity, inability to support family.	Irritation, stress related to tension with children and wife/wives, worries about family and future, rude behaviour, anxiety
Elderly People	No free space for elderly people, lack of proper clothing, hot temperature, tension due to lack of burial facilities, lack of treatment facilities, food insecurity, having no prayer room	Irritation, laziness, feeling of suffocation, crying, shouting, poor communication, rumination of distressful or traumatic experiences, low mood, emotional numbness, anxiety about their funerals
Person with disabilities	Poor living condition, no activity, loneliness, lack of treatment facilities, deprivation from basic needs, inability to walk, willingness to be active but lack of facilities for persons with disability	Irritation, loneliness, odd behaviour, no work, anxiety, sadness, not able to communicate with family members properly, crying

Source: Action Contre la Faim [142]

Assessments in the 2017 emergency in Bangladesh

Since the massive influx of Rohingya refugees since 25 August 2017, several assessments were done that include mental health and psychosocial wellbeing. Three are briefly described in this section. All of those use qualitative rapid appraisal techniques, which is often the only viable option in the context of an acute and unfolding humanitarian emergency.

Firstly, in October and November 2017 UNHCR and other service providers assessed 522 Rohingya refugees and 25 community leaders residing in Nayapara, Kerontoli/Chakmarkul and Kutupalong settlements. Participants cited the overcrowded living conditions as a primary source of safety concerns. Results obtained through the assessment, including informal interviews and field observations, indicated that many refugees were experiencing acute stress reactions, grief reactions, adaptive stress reactions, and post-traumatic stress symptoms. Older persons and persons with disabilities expressed feelings of rejection and sadness due to limited interactions with others as a result of geographical isolation [144].

Secondly, in December 2017, UNICEF, UNHCR, and child protection partners conducted a joint rapid needs assessment through interviews with among 185 respondents (randomly selected Rohingya parents or other primary caregivers) from 95 different sites/blocks including host communities. Fifty percent of respondents confirmed that they had noticed signs of distress/changes in children's behaviour in the last three months. Perceived behavioural changes by parents and other primary caregivers included crying, sadness (67% girls and 59% boys), disrespectful behaviour (41% girls and 40% boys), aggressive behaviour (23% girls and 38% boys) and substance abuse (14% girls and 31% boys). The main reasons for these changes included recollections of violence (78% boys and 66% girls), separation from family members (44% boys and 32% girls), fear of return (37.7% boys and 33.8% girls) and exposure to sexual violence before movement (44% girls and 10.% boys) [145].

Finally, in January and February 2018, IOM [146] completed a qualitative assessment focused on mental health and psychosocial wellbeing, among 229 purposely selected adults and children in three refugee sites in Bangladesh (Leda, Kutupalong and SS zone). Many adult respondents reported feeling *always sad* (74%), *always tense* (64%) and *always nervous* (48%). Similar concerns were found among children: *always sad* (50%); *always tense* (50%); *always nervous* (58%). Other indicators of distress in this population included sleeping problems, limited appetite, somatic complaints. Almost two-thirds of the adult respondents (63%) said they were constantly grieving for lost family members. Inadequate food aid, limited access to education, camp and shelter conditions, poor health conditions, movement restrictions and the uncertainty about their citizenship are among the major challenges contributing to high levels of daily stress. Among the many stress factors that refugees identified was 'not being recognized as citizens' which forty percent said they found psychologically destabilizing [147].

Mental health studies of Rohingya in Malaysia

There are no published prevalence data about mental disorders among Rohingya groups elsewhere. A large-scale community survey is currently being undertaken with Rohingya in urban and rural settings in Malaysia, using culturally adapted interview assessment tools. Preliminary analysis of data obtained from this survey yielded high rates of PTSD and depression (and other comorbid disorders) associated with compounding traumatic events and chronic stressors.

In Malaysia, in a study focusing primarily on Intimate Partner Violence in early 2017 with 75 Rohingya in an urban context (30 randomly selected individuals interviewed at their homes and another 45 in focus groups), major stress factors were fear of arrest by authorities (police, immigration), livelihood difficulties, difficulties accessing healthcare, lack of access to education for children, safety concerns, concerns about family in Myanmar, and difficulty obtaining legal documents [98, 148]. When interviewed again in late 2017 in that study Rohingya in Malaysia indicated they were very distressed by the recent violence in Myanmar.[8] In a follow up study of 245 Rohingya refugees in Malaysia in mid-2018, using the WHO UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASS-6), approximately 20% fit criteria for moderate to

[8] Personal communication C. Weldon-Mitchell (3 April 2018)

Table 4: Self-reported symptoms of severe mental distress during the last two weeks among 245 Rohingya refugees in Malaysia (data collected mid 2018)

Item from WASSS questionnaire	
Felt so afraid that nothing could calm them down most or all of the time in the last 2 weeks.	29%
Felt so angry that they felt out of control most or all of the time	13%
Felt so uninterested in things that they used to like that they did not want to do anything at all most or all of the time	24%
Felt so hopeless that they did not want to carry on living most or all of the time	13%
Felt so severely upset about the emergency/disaster/war or another event in	
their life, that they tried to avoid places, people, conversations or activities that reminded them of such event most or all of the time	26%
Felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset most or all of the time.	19%

Source: Unpublished data on ongoing research. Courtesy of C. Mitchell-Weldon [149]

severe mental health symptoms typically associated with depression and PTSD. See table 4 for details.

Mental health studies among Rohingya in Myanmar

In Myanmar, the NGO Action Contre la Faim has done various informal assessments related to mental health of Rohingya carried out before the 2017 crisis [150]. Among adults screened for mental health needs in the nutrition centres of ACF in northern Rakhine roughly one third endorsed the most extreme levels of stress or isolation available in the screening tool (Self-Reporting Questionnaire SRQ-20). Among adults in northern Rakhine State who received a full psychosocial evaluation by an MHPSS worker, 52% reported suicidal ideation [151].

Mental health studies among Rohingya in other countries

There are no systematic studies around mental health problems of Rohingya in other countries apart from a brief report that identified as major stress factors for Rohingya refugee men in the United States news about ongoing violence in Rakhine State in Myanmar, worry about caring for family members and anxiety about integrating into the American society and reaching stability for their families [152].

Contextual differences and interpretation of findings

It is difficult to draw comparisons between the Rohingya groups across different time periods and settings because the changing context will influence the levels of emotional symptoms and the capacity of refugees to cope with distress. Cultural and contextual adaptation of assessment tools, taking into consideration local idioms of distress (detailed hereunder), is essential to ensuring the comparability of the data gathered with ethnocentric categories of mental disorders, thereby minimizing the risk of transcultural measurement errors.

For planning purposes, many agencies in refugee settings use the generic WHO estimates of mental disorder prevalence in adult populations affected by complex emergences (see Table 5 below). One can expect an increase in mental disorders (e.g. depression, anxiety-related disorders) in the aftermath of an emergency. A high prevalence of mental health and psychosocial problems among Rohingya refugees is expected therefore in the years to come, even if the situation stabilizes. In addition, the mental health effects of ongoing chronic stressors in situations of protracted displacement and the rainy season in Bangladesh with expected damage of property and risk to life, will likely exact an added toll on emotional wellbeing of the refugees [153].

Risk and protective factors

Table 6 describes a range of risk and protective factors identified in the review process, including socio-demographic characteristics, ecological/ environmental factors, ongoing adversities, and history of trauma exposure.

Both qualitative and quantitative inquiries conducted with Rohingya reported a common set of risk factors for mental distress including gender (being female is associated with high levels of mental distress), exposure to potentially traumatic events (PTEs, such as torture, rape, physical violence), poverty, shortage of food and shelter, breakdown in social mores and traditions, lack of access to medical care and basic services, lack of activities, stimulation, and support in camps, restricted movement, gender-based violence, stigma about mental illness, loss of identity and exclusion. Risk factors are associated with symptoms of PTSD and depression.

Table 5: WHO projections of mental disorders in adult populations affected by emergencies [5]

	Before the emergency	After the emergency
	12-month prevalence	12-month prevalence
Severe disorder (e.g. psychosis, severe depression, severely disabling form of anxiety disorder)	2% to 3%	3% to 4%
Mild or moderate mental disorder (e.g. mild and moderate forms of depression and anxiety disorders, including mild and moderate posttraumatic stress disorder)	10%	15% to 20%
Normal distress / other psychological reactions (no disorder)	No estimate	Large percentage

Table 6. Risk and protection factors among Rohingya

Risk factors	Protective factors
• Being older • Being female • Persons living with disabilities • Exposure to (often multiple) potentially traumatic events (PTEs) • Experience/perceived threat of human rights violations • Lack of space (congestion) • Cultural stigma about mental health • Substance misuse • Sexual and gender-based violence • Breakdown in social morals/ traditions • Loss of identity and exclusion • Child separated from parents/ relatives • Separation from community members • Lack of food security • Being unable to work, pursue a vocation or further education • Poverty • Lack of access to services (particularly in Myanmar) • Lack of freedom of movement (particularly in Myanmar) • Lack of activities, stimulation and support in camps (particularly in Bangladesh)	• Extended family networks • Social support in community • Spiritual adherence and practice • Having access to health and social services


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4. ROHINGYA CULTURAL CONCEPTS AROUND MENTAL HEALTH AND MENTAL ILLNESS

4.1 Rohingya beliefs and expressions (idioms) of distress and mental illness

The Rohingya vocabulary for terms describing their emotions, feelings, and thoughts is considerable, but many of these terms are adopted from other languages, mainly Urdu, and many Rohingya are not familiar with such terms. In keeping with other culturally distinct groups, there is often no direct correspondence between Western defined diagnostic categories and the Rohingya lexicon of distress. This can complicate communication between mental health practitioners and Rohingya refugees.

The table in Appendix 4 describes the terms used in Rohingya/Ruáingga to describe a core set of psychological and emotional reactions to adversity and potentially traumatic events. Drawing on extensive ethnographic research conducted with the Rohingya in Bangladesh and Malaysia, we identified a wide array of indigenously salient terms that Rohingya commonly use to describe their emotions and distress in general and specifically related to psychological trauma. Notably, terms such as *dilor/mon* (or 'mind' in Rohingya) and *foran/jaan* (soul, often used to represent mind-soul) are used interchangeably in local descriptions of emotions or feelings to indicate they are originating from the mind or the soul; for instance, anxiety (*dilor ba-fa-na*), fear (*dilor dor*), grief (*dilor furani/ dilor pere-sha-ni*), joy (*dilor ku-shi*), worry (*dilor sin-ta*), sadness (*dilor wau-chan-ti*).

In qualitative interviews conducted with 20 Rohingya informants and focus group participants living in Malaysia, symptoms of internal avoidance (such as avoiding distressing thoughts and feelings) and external avoidance (in the form of social detachment, avoiding people, places, and activities when feeling upset) (*ba-ci-ta-kon* or *doray ta-kon*) were described and recognized by all participants as a way to mitigate stress and mental distress.[9]

[9] Unpublished data, courtesy A.K. Tay, 2018

Rohingya terms related to emotional distress

The word *waushanti/ashanti/oshanti* (sad, or 'restless/no peace in mind') is used to refer to a variety of concepts including stress, suffering, grief, and other forms of emotional pain. The term indicates the lack of *shanti* (peace). Great distress is often referred to as *beshi waushanti/ahshanti*. There is no direct correspondence between the Rohingya term and what mental health professionals would call depression or PTSD. Words commonly used by the Rohingya people to describe symptoms of depression include *monmora* or *cinta lager* (feeling sad), *mon horaf lager* or *dil hous kous lager* (feeling low mood), *chhoit lager* (not feeling well, losing interest in things, and restless mind), and *gaa cisciyaar* or *gaa bish lager* (pain in the body) and *gaa zoler or gaa furer* (burning sensation in the body). The terms *dishahara*, *hatfau aridiya*, and *maayus* are also used to describe depression and hopelessness, as is a feeling of suffocation, or *unniyashi lager*. These locally recognized terms can correspond to the psycho-vegetative and somatic symptoms associated with major depressive disorder.

Rohingya expressions relating to suicide

The Rohingya term for suicide is *hkud-kushi* (borrowed from Urdu but widely used) and *nijore morito mone hor.* Thoughts about suicide are reportedly common among Rohingya in Myanmar and Bangladesh and are linked to a strong sense of hopelessness regarding their situation, the lack of prospects for the future, and the loss of identity [90, 151]. As suicide is strongly condemned in Islam, Rohingya will often hide these ideas out of shame and fear for being judged. Field workers in Myanmar reported that Rohingya women with suicidal ideation told them that when they disclosed their thoughts to their friends and family, the reaction was often judgmental (being told that they would go to hell) which further increased their agony and shame.[10] In a study in 2008 among women with young children in the registered Rohingya refugee camps in Bangladesh, 61.7% said affirmed having had thoughts of ending their lives [141.] In 2013, in study of registered Rohingya refugees in Bangladesh, 13% of participants endorsed suicidal thoughts [90]. Informal follow-up interviews by the researchers with NGO partners providing counselling services revealed that of the individuals referred from the study, some had an active plan to commit suicide such as having a rope at home or the plan to ingest pesticides. These self-described suicide plans mirrored information from informal key informant interviews with primary health care staff in Kutupalong and Nayapara camps on prior suicide attempts they were aware of.

Rohingya terms related to severe mental disorders

A person who is in a psychotic or manic state are referred to as *fol hoyee gioye* ('mad' or 'crazy') and *matha horaf hoye*; or are said to be *demag harap hoyee* or *demagi halot thik nai* (literally: 'the brain is not working'). Individuals who reported these syndromes also reported visual or auditory hallucinations and delusional ideas. Appendix 5 presents Rohingya terminology related to severe mental disorders including words indicating psychosis (*foul* and *matá-horáf*) and manic states (*demag-chóut/horáf*, *soudou*) and *arsu-khasu.* Anecdotal evidence from northern Rakhine State indicates that in the absence of formal mental health services, family members sometimes brought people who were perceived as 'mad' to medicine peddlers who provided them clandestinely with fluphenazine injections (long acting anti-psychotic medication).[11]

Rohingya terms related to intellectual and developmental disabilities

The terms *buddi hom/kom* (less intelligent), *demagi-khomzari* and *demag horaf* or *demag halka* ('the brain is not working') or *ada mata* or *ada fol* ('half head') or *mata chout* (absent minded) are often used interchangeably to describe individuals with intellectual disabilities. These terms are often stigmatizing and pejorative. Appendix 6 summarizes Rohingya terminology related to intellectual and developmental disabilities.

[10] Personal communication from MHPSS workers in Myanmar who prefer to remain anonymous.

[11] Personal communication from MHPSS workers in Myanmar who prefer to remain anonymous.

Rohingya terms related to seizures

According to clinical observations made by mental health professionals in Cox's Bazar, although there have been reported cases of seizures and convulsions (commonly referred to in local terms as *chhoafiara* (also written as *choa-fera* or *swa firah*), it is not always clear whether these were organic (epilepsy) or psychogenic (pseudo-seizure/non-epileptic seizure) in origin. In these cases, according to the Quran, the traditional belief is that the person is under possession by supernatural forces or sprits (*Gin e payee* or *challan utty*). Other common Rohingya terms (and synonyms) used to describe physical manifestations of seizures include *khézani*, *dourr-forani* (convulsion), *atikkya-béhouñj*, *haaf-chuça*, *hafani*, *demagi*, *haaf/chóit* (epileptic fit) and *kézarai* or *asa-hasn*.

Koro-like syndrome

Koro is a cultural syndrome in parts of Asia involving the belief that there is shrinking of the male genitals into the abdomen which is thought to ultimately result in death [154]. Koro-like symptoms have been recorded in a case report of a Rohingya male refugee in Malaysia, who presented with major depressive disorder accentuated by extreme feelings of religious guilt [155].

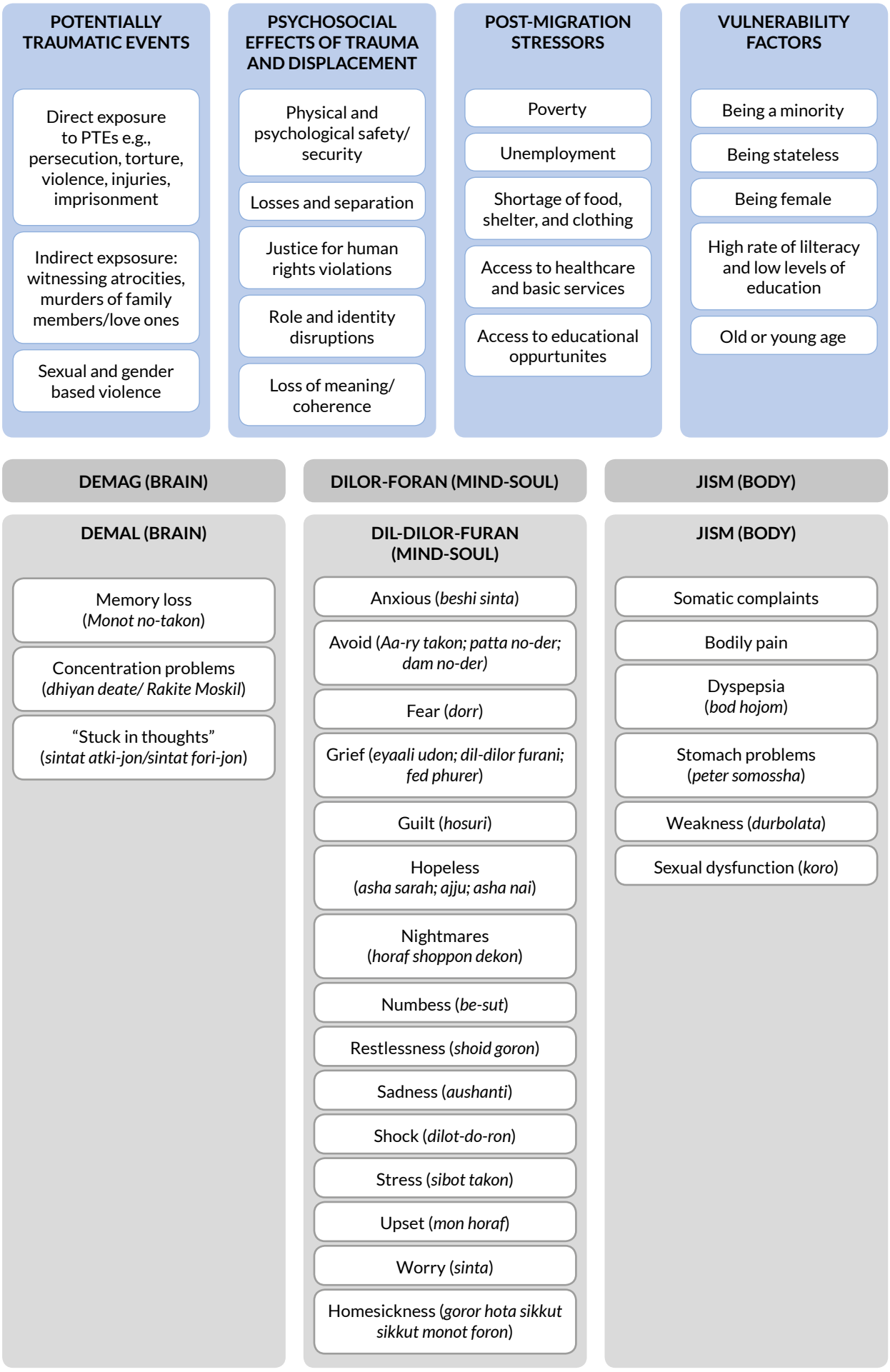
Spirit possession

A prevailing folk diagnosis is possession by a spirit (*jinn* in Arabic and *fawri* in Rohingya) or ghost (*saysee*). This involves the temporary occupation of an individual's mind and body by spirits or ghosts. *Jinn* are supernatural creatures (made of fire) capable of metamorphosing into human, ghost, or animal appearances. According to prevailing belief, there are good and bad *jinn*. In traditional Islamic folklore and the Quranic literature [156], individuals possessed by the *jinn* are frequently seen as acting erratically, experiencing visual hallucinations and paranoid delusions (e.g. suspicious of homicidal ideation of an unknown person). *Jinn* possession is widely described in clinical observations amongst Muslim patients [156, 157]. Spirit possession is also thought to lead to anti-social behaviour. Both benign and malignant sprits are thought to be active at night and exist in different locations. Benign spirits are thought to be found in Islamic sacred religious places such as mosques. Malignant spirits are believed to manifest themselves especially in remote areas, rivers, latrines, or Hindu/Buddhist cemeteries. Malignant spirits are attracted to dirt and since menstruation blood is considered dirty, a woman is considered particularly vulnerable to attacks by *jinn* during menstruation, during delivery and the forty days after delivery. If a *jinn* attacks the new-born child it may become insane or handicapped [158].

The behaviour of the possessed person may give hints about what the spirit wants. For example, individuals possessed by a spirit who wants to 'marry' them, tend to display anti-social behaviour, oblivion to social and cultural norms, delusional thoughts, hallucinations, talking to themselves, theatrical and agitated behaviour, sudden increase in appetite, but also anhedonia, lack of interest in daily routine/sex. Rohingya people usually do not seek medical or psychological treatment if they believe a person is possessed by a spirit but approach traditional healers who perform traditional rituals, religious practices and prayers.

In a clinical context, a culturally informed assessment with a basic understanding of the explanatory models of illness and relevant cultural practices is needed to enable clinicians to distinguish *jinn* possession from psychotic presentation or epileptic seizures particularly in the Rohingya people. Experiences of being possessed are widespread. In 2013 survey among Rohingya refugees in Bangladesh the respondents indicated that they were feeling or believing that they were under a spell (10%), possessed by a bad spirit or demon (10%), or that they were controlled by an unidentified black shadow or black magic (6%) [90].

Figure 1. A schematic diagram of an explanatory model of psychological idioms of distress among Rohingya refugees affected by mass violence and displacement (adapted from Tay et al., 2017).



4.2 Concepts of the self/ person

Rohingya explanatory models for mental and psychosocial problems are based on divisions between the brain (*mogos/demag*), the mind (*dil-dilor/ mon*), the soul (*jaan/foran*), and the physical body (*jism/gaa*). These constituent components represent concrete aspects of the person (the brain and the body) and abstract aspects (the mind and the soul) and together they provide important insights into how mental health and psychosocial problems are expressed and understood in the Rohingya context.

Mind-Soul

In Rohingya/ Ruáingga, the mind is considered the origin of emotions, affect (e.g. joy, love, anger, grief, sadness), reactions, and attention. The brain is the locus of memory, cognitions, and thoughts. The body is seen as a physical entity that is connected to the brain and the mind. There are no clear distinctions or boundaries between the mind and the soul as the array of syndromes described or expressed by Rohingya as originating from these entities overlap to a large extent. Both the mind and the soul however are perceived differently: the soul is the genesis of life, whereas the mind controls emotions and feelings. The soul is associated with all core aspects of the person including the brain, physical body, mind, and sensations.

Importantly, there are complex bi-directional pathways between the brain, mind-soul, and body by which psychological trauma affects mental health, leading from the mind-soul/brain to the body and vice-versa (see diagram in Figure 1).

The conflation between mind and soul as opposed to the brain (*mogos/demag*) or the body (*jism/ gaa*) as separate physical entities is evident in the local expressions of distress. There are complex interrelationships between mind/soul, brain, and body as conceptualized and understood by the Rohingya. This explanatory model is important to understand how socio-cultural experiences shape the mental health (with manifestations in the mind/ soul, the brain, and the body) and behaviour. There is an implicit understanding in the Rohingya language that the mind-soul can be affected by emotional perturbations, as described in a range of psychological and emotional reactions in Rohingya such as fear, anxiety, grief, stress, sadness, worry) with somatic symptoms (*gaa cisciyaar* or 'pain in the body'). Most Rohingya have limited familiarity with international concepts of mental health and may express terms related to the mind-soul in ways that mental health practitioners find confusing.

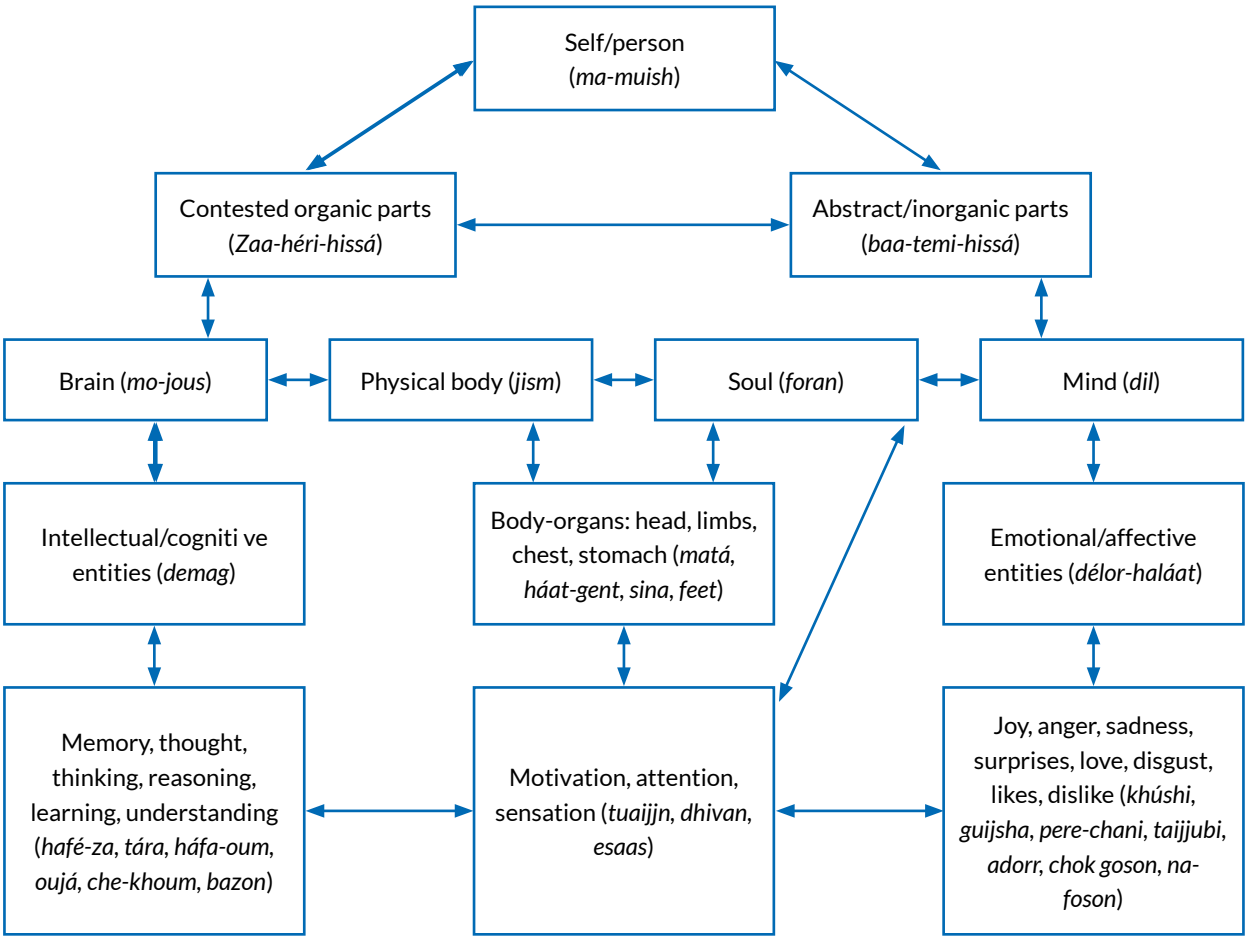
4.3 Religion, faith, and traditional healing and their role in mental health and psychosocial support

Religion is a primary source of strength and support for Rohingya, with many relying on religiousness and a sense of duty to communities and their families [159] to help cope with the oppression they have faced throughout their lives [160]. Traditional practices, however, are increasingly difficult to observe for Rohingya in Myanmar due to restricted freedom of movement and lack of available religious services. Refugees in Bangladesh and Malaysia have freedom to practice their religion.

In the case of spirit possession (by *jinn/fawri* or ghosts), it is a common practice for Rohingya to seek help from traditional healers and religious leaders such as *imam* or *ustād* who then conduct a ritual where they recite verses from the Quran to rid the person of the *jinn*. Possessed individuals appear psychologically disturbed with significant behavioural changes. Some persons who are considered possessed may suffer from emotional disorders or dissociative disorders, while others may have epilepsy or psychosis. Understanding Rohingya traditional help-seeking behaviour and involving traditional healers in interventions is important in the provision of culturally appropriate psychological treatment and psychosocial support.

Traditional healing methods play an important role in the treatment of mental health problems in the Rohingya culture, for many reasons. An important reason is the lack of familiarity with western concepts of mental health and treatment methods such as counselling or psychotherapy. Another reason is that serious mental health problems (such as psychosis, epilepsy, mania) are perceived as socially unacceptable behaviour. People with severe mental health conditions are often believed to have been cursed by Allah for their own misbehaviour. Lastly, traditional healing practices often allow for issues to be addressed privately or even secretively between

Figure 2. The core components of the self-represented in the Rohingya terminology



the healer and patient, thus minimizing the risk of ostracism and stigma in the community.

Rohingya use different traditional forms of medicine [139]. There are various kinds of healers. Some are in contact with a specific *jinn* and mainly administer remedies according to medicine books written in Urdu (and sometimes in Hindi). This type of healer is called *bóddo*, *boiddo*, *bouid-dou* or *bodor*. They are usually men, but there are reports of female *bóddo* [84]. Others, who are in contact with a *jinn* administer remedies according to the guidance provided by the *jinn* (*fawri*). Other healers receive their powers through inheritance [74]. There are different types of traditional and informal healers for a range of mental health problems including nightmares, psychosomatic complaints, spirit possession, and common physical ailments (see table 7). Examples of Rohingya healers are 1) the spiritual healer (*bouid-dou*) who can also serve as a fortune teller (*goi-noi-ya*); 2) the religious scholar (*fóu-yirr*); 3) the Quran reciter (*mou-loi/habés*, *moulvi/mullah*); and 4) the unlicensed practitioner using western medication (*daac-torr*). Within the refugee settings in Bangladesh, religious and traditional healers are active and the population seeks their help [161].

Healers are consulted for many different problems, among them malnutrition, mental health conditions, seizures, as well developmental delay and autism. Such problems are often attributed to malevolent spirits – *jinn* – or the 'evil eye'. The evil eye can be inflicted upon a person when any human with malevolent intent or 'ill will' looks at them. It is sometimes thought to simply result from compliments said about a child, for example. The evil eye can cause symptoms such as a lack of enthusiasm, loss of appetite, and sleep difficulties. Pregnant women are thought to be particularly vulnerable to the evil eye. Rohingya distinguish two cultural syndromes related to malnutrition: *léça biaram* ('thin illness') and *tom zu biaram* (illness that causes loss of strength) that are both attributed jinn possession [74].

Traditional healers often produce amulets (with herbs and other natural products) combined with a verse of the Quran on a scrap of paper to protect the bearer from bad spirits and the evil eye. Those amulets are often worn by children (either around the neck or the hips) and some adults (especially pregnant women) [82]. Some healers also provide holy water using quotes from the Quran above a glass of water that is then thought to absorb the power of the words. Methods of traditional healers vary. Some healers use non-invasive rituals such as blowing smoke over the body or methods which put the body under stress (such as restraint with rope, controlled burning).

Rohingya have a long history of using medicinal plants for treating various health problems and ailments including epilepsy [162]. An ethno-medicinal survey conducted amongst Rohingya families living in the villages of south-eastern Bangladesh identified 34 plant species used to treat 45 ailments ranging from simple headaches to highly complex eye and heart diseases [163]. For the most part, the Rohingya use medicinal plants to treat fever, coughs, cuts and wounds, cold ailments, tooth disease, hair loss, skin diseases, and weakness.

4.4 Help-seeking behaviour

Rohingya refugees tend not to seek formal help for mental health problems, which may be partly related to the limited familiarity with concepts around mental health and formal mental health care and to the belief that mental health conditions are a sign of weakness and something to be ashamed about. Only when a problem is perceived as physical in origin will medical care be sought.

Research among Rohingya in Malaysia identified as barriers to help-seeking (for intimate partner abuse): shame, social stigma, concerns about confidentiality, concerns about legal documentation, and language barriers. Because of stigma, individuals with severe mental health problems are often taken care of by family members within communities, and in some instances are ostracized by community members. Among 72 Rohingya in Malaysia who were asked if they would seek help if they were feeling very sad and overwhelmed by difficulties, 63% said they would probably do so; most would turn to family and close friends and a minority indicated they would be inclined to seek professional help. In a related study with 245 Rohingya in Malaysia in 2018, 80% indicated they would seek help for intimate partner abuse, with a majority preferring to go to family (80%), religious leaders (70%), local organizations (57%) and only 10–12% indicating that they would go to a doctor or mental health specialist [98].

Experience in Myanmar and Bangladesh shows that if the quality of the relationship between MHPSS worker and client is strong, and particularly when the client is given space to express their experiences freely and confidentially, Rohingya clients can be motivated to adhere to treatment.

Table 7: Traditional and informal healing practices in Rohingya communities in Myanmar

Types of healers		Types of healing methods applied		Types of disorders healed	
Rohingya terms	English terms/ equivalents	Rohingya terms	English terms/ equivalents	Rohingya terms	English terms/ equivalents
Bouid-dou (Spiritual healer)	A healer who heals spiritual/psychosomatic disorders using healing methods based on tradition/scriptures derived from the king, Suleman	Áañt (bú-on)	A traditional healing method consisting of music, dancing, and singing	Jinn/fawri/ason, bisor, foul, jadu-furna	Spirit-possession, madness, spellbound, evil/ devil/possession
		Necháb (bóyoh)	A traditional healing method consisting of meditation	Jinn/fawri, ho-raf-kuap	Spirit-possession, diagnosis of disorders, nightmare…
		Zára-phuá (go-rón)	A healing method consisting of amulet, prayed/blown water/oil/ the patient's body	Jinn/fawri, rohari, jesmani	Spirit possession, psychosomatic complaints, nightmares
Fóu-yirr (Religious scholar)	A healer who heals spiritual/psychosomatic disorders using healing methods based on Quran/spiritual messages received from link	Necháb (bó-yoh)/ Fóurr-ali	As mentioned above (religious passages)	As mentioned above	As mentioned above
		Zára-phuá (go-ron)	As mentioned above	As mentioned above	As mentioned above
Mou-loi/ Habés (Moulvi/ mullah/ Quran reciter)	A mullah/ he who memorises Quran and heals spiritual/ psychosomatic disorders using methods based on scriptures, Quran-recitation and prayer to Allah	Zára-phuá (go-ron)	As mentioned above	As mentioned above	As mentioned above
		Khotóm-fóra	A religious healing method consisting of recitation of Quran	Be-araam, mojkhelaat, mawsibot dor goron	Illness, problems, getting rid of dangers
		Dhuá-dhuros	A religious healing method consisting of prating for the patient	As mentioned above	Illness, problems, getting rid of dangers, curses
Goi-noi-ya (Fortune teller)	He/she who heals spiritual/psychosomatic disorders and tells fortune by using methods: meditations, signs of palm	Necháb (bo-yon)	As mentioned above	As mentioned above	As mentioned above
		Gou-noun	A traditional/scripture-based healing/fortune-telling method consisting of meditation, sign…	Gou-noum, chis-bish-tuwon	Telling fortune, finding missing things…
Daac-torr ('quack')	A person who treats bodily ailments using informally learnt techniques of medicine	Daac-tory	An unlicensed treating method consisting of informally learnt techniques of medicine, western drugs	Gora-be-a raam, zoor, samorr-be araam…	Basic/common diseases, fever, skin disease, common cold, minor injury, diarrhea, pain, ache
Dhabai-biari	He/she who heals bodily ailments using herbal/ self-made drugs	Sáas-tory	A traditional healing method consisting of self-made drugs: herbs/ plant-based things	Hat/teng-bañga, fetor, be-araam	Broken limbs, stomach disease
Dóu-roni (TBA)	She who attends deliveries using traditionally learnt methods	Phuá-dórom	A traditional method of attending births	Bayja-outi mojkhel-fua doron	Difficult deliveries

5. INTERVENTIONS TO IMPROVE MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING OF ROHINGYA

In the development and adaptation of any MHPSS interventions, it is important to combine community-based psychosocial approaches with clinical approaches grounded in an experiential/theoretical framework that addresses the core aspects of the experience of forced migration and displacement. In a stepped care model, subpopulations with different symptom profiles and severity are allocated to different levels of services and support. It is important to distinguish between people whose symptoms may be transient or may be amenable to minimal intervention versus those who need more intensive or specialized clinical support. The various approaches can be unified in a system of multi layered services or supports to which various sectors (such as health, protection, education) can contribute [164]. In the 2018 Joint Response Plan for the Rohingya Humanitarian Crisis explicit references are made to the need to integrate MHPSS aspects into multiple sectors [4]. Since September 2017, an increasing number of actors have been involved in MHPSS for Rohingya refugees in Bangladesh, but the overall MHPSS response remains significantly under resourced and needs to be strengthened [165]. In their response, many aid organisations initially focused on the provision of psychological first aid and basic forms of psychosocial support and advocating for the basic needs of people with mental health conditions to be met. Reports in the popular media and other publications for the general public often focused on psychological trauma and trauma-counselling [147, 153, 166–169] but the activities around mental health and psychosocial support encompass many other aspects. IOM [146, 170] estimated in April 2018 that around 4% of the Rohingya refugees would need clinical specialised interventions; 40% would need some form of non-clinical focused interventions while the vast majority could benefit from delivery of basic services with social considerations, for instance linking food and nutrition programmes with positive and bonding parenting programmes [146] The majority of the mental health and psychosocial services available in Cox's Bazar are located in the community level and in the non-specialised interventions; in contrast, there is a significant gap in the provision of specialised services, services that are targeting high risk groups as youth, and in mainstreaming psychosocial considerations in the provision of basic services [171].

This chapter provides an overview of the broad range of MHPSS activities for Rohingya refugees in Bangladesh, with some references to the situation in Myanmar and Malaysia.

5.1 Role of the social sector in MHPSS

Justice and protection

In Rohingya communities in Myanmar, cases of violence and abuse such as disputes or intimate partner violence are traditionally adjudicated by the *sordar* or (sódor) who are male community leaders appointed by religious leaders or elders[74]. For more complex and serious issues, the *ukkata*,[12] or the designated chairmen of each area who are part of the national governance system, are called upon to adjudicate in these incidents, with unresolved issues being referred to the police authorities. These community justice and protection mechanisms have been in place for generations and are traditionally dominated by men, with limited female participation.

In refugee settlements in Bangladesh, the army appointed block leaders called *majhis* who are tasked with settling minor disputes whereas severe incidents are handled by governmental officials in charge

[12] In the camps for IDPs in central Rakhine this could refer to the camp management committee members where as in northern Rakhine State it would refer to village leaders/township administrators.

of the site and the Bangladeshi police authorities. *Majhis* are not traditional leaders or elders and are not necessarily respected community members. Since the '*majhi* system' was not established with the participation of the Rohingya communities it lacks representation of and accountability to the refugees [172].

Information and communication with communities

Since late 2017, humanitarian agencies have trained hundreds of community outreach volunteers from the Rohingya and host communities to assist in sharing updated information on policies, services and assistance with the refugee community, providing feedback on community concerns and views and identifying and referring persons at heightened risk to specialized services and contributing to the implementation of community solutions.

Community-based psychosocial work

There is no published literature on the effects of community-based psychosocial interventions with Rohingya but experiences with other ethnic groups from Myanmar suggest positive effects interventions that focus on community empowerment, sharing of experiences and training lay counsellors [126, 173–175]. Experience in Myanmar from NGOs such as ACF showed that increasing the availability of social workers and providing parental psychosocial support enabled Rohingya parents to address behavioural changes within their children [160] Group interventions emphasizing peer support and collective problem solving have also shown promise in addressing mental health and psychosocial needs and intimate partner abuse among Rohingya in Malaysia.

5.2 Role of the formal and informal educational sector in MHPSS

Regular education

In Myanmar, Rohingya have limited access to education [176]. Among Rohingya refugees who arrived in Bangladesh in 2017, 76% of those above 15 years of age had received no education [122]. Although registered Rohingya refugees in the camps in Bangladesh can participate in a government-sanctioned UNHCR school programme, the local authorities do not allow formal education to be provided for Rohingya refugee children who arrived since August 2017 or who were previously unregistered. NGOs and UN agencies offer refugee children and adolescents access to informal educational opportunities with local and Rohingya teachers as instructors [177]. Movement of women is often restricted in the camps due to family members' concerns for their safety and security, and due to cultural and religious constraints on girls and women which makes it difficult for girls to participate in educational activities if gender considerations are not incorporated into programming. Early marriage remains a widespread cultural practice, and boys are often encouraged to find a job to support the family.

Madrasahs

Religious schools (*madrasahs*) play an important role in the Rohingya communities where few schools are available. In the refugee settlements in Bangladesh the *madrasahs* continue to play a significant role. Hundreds of such schools, often very small and attached to a makeshift mosque, have been established in the last months of 2017, often with the support of faith communities from Bangladesh and beyond. The situation is similar in Malaysia where Rohingya do not have access to local schools. Such religious schools can be important in bringing back a sense of normality and provide a sense of belonging. Rohingya often seek help for what they feel are internal or invisible pain from *madrasah* teachers and religious leaders, who could therefore benefit from basic training on mental health issues. Some of these schools are also serving as quasi-orphanages, housing both orphaned children and children whose families feel they do not have the resources to support them. However, the emphasis on religious teaching and education as a substitute for formal education is a key concern.

5.3 Role of the health sector in MHPSS

Access to general health care

In Myanmar, Rohingya communities continue to experience discrimination in access to healthcare and cannot self-refer to medical service centres outside their designated living areas [160]. In Bangladesh and other neighbouring countries hosting refugees, Rohingya confront formidable challenges in accessing appropriate healthcare and mental health services due in part to their stateless status, inadequate legal protection and safeguards, lack of financial means, and the deterrent nature of immigration policies against refugees and asylum seekers in these countries.

The huge refugee settlements that have been established in Bangladesh in late 2017 initially lacked access to medical services. Many organizations and national and international volunteers travelled to Cox's Bazar to support health care provision for refugees, through the establishment of temporary clinics, mobile clinics and field hospitals. Many short-term missions now have ended, but as of June 2018, 107 agencies and organizations are still active in providing health services.

Mental health policies and mental health systems

Although a mental health policy is embedded within the national health policy frameworks of Bangladesh, Myanmar, and Malaysia [178–180], limited attention has been given to access for care to ethnic minority and refugee populations. For instance, in Myanmar, the majority of ethnic minority populations live in conflict-affected areas with limited access to medical or mental health care. Even in Bamar-dominated areas, mental health care is very limited, as infrastructure and services have not been developed, except for some services/hospitals in Yangon/ Mandalay.

For the most part, conventional models of psychiatric care remain a prevailing practice in Myanmar and the refugee-hosting neighbouring countries (Bangladesh, Malaysia, and Thailand). The bulk of the national mental health budget is allocated to ensuring access to essential psychotropic medications and the operation and maintenance of psychiatric institutions for persons with mental illness. There are anecdotal reports of self-medication with anti-psychotics that are bought over the counter available from pharmacies and from medicine peddlers.

There is some research on the effectiveness of psychotherapeutic interventions for populations in and from Myanmar, but the quality of the evidence is not strong [181]. Psychotherapeutic interventions are also not widely used in the mental health sector in Bangladesh [182, 183]. In Malaysia, there is a longer tradition of psychotherapy and counselling but the services are mainly used by nationals from higher socio-economic strata [184], Access to psychotherapy and other mental health interventions for refugees and migrants is poor with the Rohingya having even lower utilisation rates than other refugee groups [185, 186].

Integration of mental health in refugee settings

An overarching goal in the refugee settlements in Bangladesh is to integrate mental health within basic health services, using the mhGAP materials developed by WHO [187], and particularly the humanitarian version that was developed jointly with UNHCR [188]. These tools aim to improve the identification and management in the general health care system of a range of mental disorders including depression, stress-related disorders, psychosis, and epilepsy. Training for health workers in mhGAP methods has been conducted by WHO, the Government of Bangladesh and UNHCR. There is a lack of standard procedures and criteria for the referral of cases of severe mental and neuropsychiatric disorders (e.g. psychosis, epilepsy) and no clear referral pathway to tertiary mental health services for severe mental disorders. In addition, there are minimal comprehensive rehabilitation services in the district hospital and Upazila Health Complexes. A mental health service run by a government psychiatrist and a psychologist (provided by ACF) was recently established in the district hospital (as of December 2017) to provide specialized care for severe mental disorders and outreach within the refugee camps.

According to the Mental Health and Non-communicable Diseases Situation Assessment Report released by WHO in December 2017, the primary

care system in Cox's Bazar was overwhelmed by the influx of Rohingya refugees and these services were ill-equipped to treat mental disorders. Increasingly, health posts or clinics run by NGOs like Gonoshastaya Kendra and Medical Teams International, have recruited psychologists or psychosocial counsellors as essential staff of primary health care centres. This is consistent with the 'Package of Essential Health Services for Primary Healthcare level in the Refugee camps in Cox's Bazaar' that was developed by the Government of Bangladesh, UN agencies and NGOs in November 2017 [189]. This package requires that at health post level, Psychological First Aid is provided along with identification of signs of mental disorders and referral. At health centre level (with a coverage area of around 20,000 persons) the following services should be provided: 1) Management of common mental disorders by primary health care physicians following mhGAP training; 2) (referral system) for counselling and specialized psychiatric management; and 3) supportive supervision by visiting specialists (psychiatrists and clinical psychologists).

5.4 Coordination of MHPSS services for Rohingya refugees in Bangladesh

Many organizations are currently involved in providing psychosocial support for Rohingya refugees. Major service providers include the Bangladesh government (the Ministry of Health and Ministry of Women and Children); UN agencies (IOM, UNFPA, UNHCR, UNICEF); international NGOs (ACF, Danish Refugee Council, Handicap International, the International Rescue Committee, Medical Teams International, MSF, Relief International, Save the Children and World Concern); national NGOs (BRAC, Gonoshasthaya Kendra, Mukti); and other international organisations such as the Danish Red Cross and the International Federation of the Red Cross and Red Crescent Societies (IFRC). Most of these organisations have deployed psychologists and psychosocial counsellors in the refugee settlements. Some organizations have also provided psychologists in health facilities of the national system, for example in Baharchara (through ACF) and Ukhiya Upazila Health Complex (through MSF).

The coordination of health services remains challenging. Overall coordination of the humanitarian health response has been organised in the Health Sector Coordination Group, led by the WHO. Under this health sectoral group, a coordination group for MHPSS has been established in the aftermath of the humanitarian crisis in 2017. It is currently led by ACF and the Bangladesh-based NGO BRAC with over twenty partner organisations participating in the meetings [110].

A myriad of challenges, including a lack of coordination and cooperation amongst stakeholder agencies and organizations, mental health professionals and specialists, a lack of community-based case detection and referral systems, and weak linkages of MHPSS with other sectors (e.g. health, SGBV, nutrition, child protection) continue to act as an impediment to the delivery of MHPSS services. The MHPSS coordination group regularly updates a 4W (Who, What, Where and When) mapping to document which kind of services are being provided. In June 2018, over 20 organizations were involved in providing mental health or psychosocial services [171].

5.5 Documented experiences involving mental health and psychosocial support for Rohingya

The Rohingya in Myanmar and in neighbouring countries are a severely underserved population with regards to MHPSS. Various agencies have implemented programmes for MHPSS support to this population. In Cox's Bazar district at least twenty organisation are involved in MHPSS. This section briefly describes some of the documented examples of MHPSS programmes for Rohingya in Bangladesh.

UNHCR in Cox's Bazar

In 2014, UNHCR started a pilot for a case management approach for psychosocial support in the two registered refugee camps in Bangladesh. The work was initiated by an international mental health expert and a Bangladeshi psychologist, as the first step to establishing MHPSS services for the Rohingya refugees, with the aim of streamlining MHPSS across different stakeholder agencies and organizations charged with the humanitarian response [190]. Key components of the pilot MHPSS programme were strengthening self-help mechanisms at the

community level (via self-awareness training) through work with by religious and community leaders and awareness raising activities around of psychological wellbeing and coping skills Additional recreational activities were conducted to promote social cohesion and team work, with the aim of improvising self-confidence, leadership, and creativity amongst young adults [190]. In 2015 and 2016, UNHCR provided training with the mhGAP Humanitarian Intervention Guide for 60 staff from different organizations working in the refugee response system. This included general practitioners, medical assistants, nurses, health counsellors and psychologists.

In 2018 the activities around MHPSS have been substantially scaled up with activities centred around three main priorities: 1) strengthening community based psychosocial support (through training of community volunteers), 2) introducing scalable psychological interventions such as Integrated ADAPT Therapy [191, 192] and Group Interpersonal Therapy for Depression [197]. The MHPSS team consists of six mental health professionals (four psychologists and two psychiatrists) who focus on capacity building and support to UNHCR's partners such as NGOs and the government.

IOM in Cox's Bazar

The International Organization for Migration supports the expansion of primary, reproductive and secondary health care services as well as public health and outreach campaigns. Since August 2017, IOM's Mental Health and Psychosocial Services (MHPSS) programme reached almost 5,000 people with activities such as individual counselling, in-patient care, patient referrals, and community mobilization activities.[13] The current MHPSS programme has various components including the provision of direct assistance around basic needs, community mobilisation to strengthen resilience, organizing community and healing activities; establishing community support groups for specific group such as unaccompanied children, youth (girls and men), older people or around sports and livelihood activities.

[13] Personal communication Olga Rebolledo, IOM Cox's Bazar (July 29 2018)

ACF in Cox's Bazar

Since 2011, ACF implements a Mental Health and Care Practices program for Rohingya refugee mothers in Kutupalong and Nayapara sites. In a study with 500 women who participated in the programme, 240 were assigned to the intervention arm and 260 to the control arm. The intervention group received psychoeducational lessons about relieving stress, coping with stressors, breastfeeding and feeding practices, child development and psychosocial care, health and hygiene practice, home health practices, and resources for care at the family and community level [194]. At 7-month follow up, the participants showed a significant reduction in depressive symptoms and increased awareness of childcare practices compared to the control group.

Médecins Sans Frontières in Cox's Bazar

Médecins Sans Frontières have been working in Cox's Bazar since 2009 delivering mental health counselling and psychiatric care to both the Rohingya refugee population and the host community. With the large influx of refugees beginning August 25, 2017, activities expanded and now include counselling and psychiatric care in Kutupalong, Balukhali, Nayapara, Unchiparan, Jamtoli health centres, counselling and psychoeducation in 10 health posts in the refugee settlements, and psychosocial interventions in the Rubber Garden Reception Centre including play sessions for children, psychological first aid, and psychoeducation.[14]

BRAC in Cox's Bazar

The Bangladesh-based international NGO BRAC provides psychosocial support to the Rohingya refugee community by implementing a four tiered psychosocial model through group sessions based in Child- Friendly Spaces as well as individual sessions for cases identified during routine home visits. This delivery approach involves four levels of staff. As of April 2018, BRAC employed 308 barefoot counsellors (mainly recruited from the Bangladeshi host community) and 38 para-counsellors in the Cox's Bazar District to provide psychosocial support to children and adolescents. These frontline workers are supervised by eight counselling psychologists based in Cox's Bazar and two experts who make routine trips to Cox's Bazar and manage more complex cases[195].

5.6 Towards a multi-layered system of services and supports

Following the release of the IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings [164], a consensus has emerged that MHPSS services need to be conceptualized and organized as a multi-layered system of services and supports. See figure 3 with multi-layered MHPSS services. This has important implications, for professionals working within (mental) health services (including specialists with advanced mental health training) and those who establish and strengthen community-based psychosocial activities. MHPSS services and support are not merely the realms of a handful of specialists but need to be realized within existing sectors, such as health, protection and education.

Layer 1: Social consideration in basic services and security

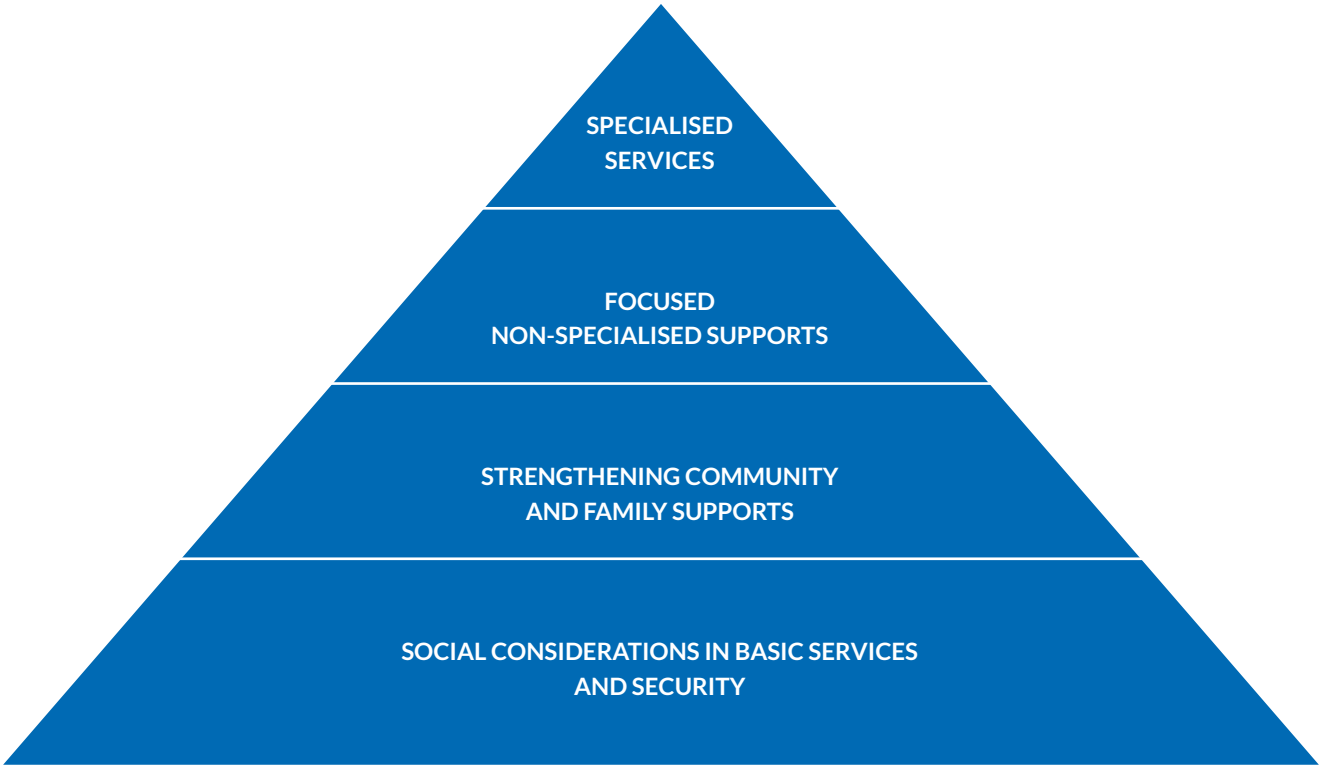
Ensure that the provision of basic needs and essential services (food, shelter, water, sanitation, basic health care, control of communicable diseases) and security is done in ways that respect the dignity of all people, taking into consideration gender mainstreaming approaches, and is inclusive of those with special vulnerabilities, but which also avoids exclusively targeting a single group in order to minimize tension among the beneficiaries, and prevents discrimination, stigma and potential further distress.

Layer 2: Strengthening community and family supports

Promote activities that foster social cohesion among refugee populations, including supporting the re-establishment, or development, of refugee community-based structures that are representative of the population in terms of age, gender, and diversity. This includes the promotion of community mechanisms and family supports, which protect and

[14] Personal communication MSF Holland and MSF Spain (May 29 2018)

Figure 3: IASC pyramid of multi-layered MHPSS services and supports [164]



support members through participatory approaches. Examples of interventions of this type include Child Friendly Spaces, community self-help groups and setting up networks of refugee volunteers who provide psychosocial and practical support to other refugees.

Layer 3: Focused psychosocial support

Provide emotional and practical support through individual, family or group interventions to those who are having difficulty coping by using only their personal strengths and their existing support network. Usually non-specialised workers in health, education, child protection or community services deliver such interventions, after training, and with ongoing supervision. Examples are the range of manualized scalable psychological interventions such as Problem Management Plus [196], Group Interpersonal Therapy for Depression [197] and Integrated ADAPT Therapy [192].

Layer 4: Clinical services

Deliver and ensure fair and equitable access to clinical mental health services to those with severe symptoms or a level of suffering which has rendered them unable to carry out basic daily functions. This group is usually made up of those with pre-existing mental health disorders and emergency-induced problems, including: psychosis, drug abuse, severe depression, disabling anxiety symptoms, severe posttraumatic stress symptoms, and those who are at risk to harm themselves or others. Mental health professionals usually lead these interventions, but many tasks can be performed by other health staff (doctors and nurse) if they are well trained and supervised in the use of the mhGAP materials [188].

6. CHALLENGES IN PROVIDING CULTURALLY RELEVANT AND CONTEXTUALLY APPROPRIATE SERVICES FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT TO ROHINGYA REFUGEES

An impressive humanitarian aid operation has been set up for Rohingya refugees in Bangladesh that includes MHPSS, but major challenges continue to exist, associated with care delivery within an overburdened health system with limited human resources and infrastructure.

A long history of persecution, violence, and discrimination towards Rohingya in Myanmar compounded by prolonged conditions of statelessness and deprivations increase their vulnerability for psychological distress and mental disorders. High rates of SGBV and the lack of privacy and safe spaces, and limited access to integrated psychosocial and mental health support for Rohingya girls and women remain issues of concern. Limited familiarity with western concepts of psychology and trauma counselling remains a significant challenge for providing psychological treatments or therapies. Even when MHPSS services are available, Rohingya refugees may be unable or unwilling to utilize them. One important reason may be a limited understanding among MHPSS providers of the culture, customs, language and religion of Rohingya refugees. It is important to tailor services to the perceived needs of refugees and have specific attention for factors such as language, culture and social structure.

6.1 Language

The Rohingya language has many similarities with the Chittagonian dialect that is spoken in the area around Cox's Bazar, but is not identical. Many humanitarian staff involved in the Rohingya refugee response are not familiar with the language. When language barriers are present, collaboration with Rohingya/Chittagonian speaking colleagues is essential for accurate assessment and treatment delivery. Given the lack of formally trained interpreters, the use of informal or ad hoc interpreters from the community (or family) may be inevitable. See the tables in Appendix 4–7.

6.2 Concepts of psychological problems

Not much is written about the ethno-psychological concepts prevalent among the Rohingya, but it is clear that the body-mind divide from standard professional psychiatry and psychology is not shared by the Rohingya. For Rohingya, the core components of the self/person include the brain (*mogos/demag*), the mind (*dil-dilor/mon*), the soul (*jaan/foran*), and the physical body (*jism/gaa*). The mind is considered as the origin of emotions, reactions, and attention while the brain is the locus of memory, cognitions, and thoughts.

The Rohingya language has words for emotional states but does not have concepts that are equivalent to the psychological concepts of depression, posttraumatic stress disorder or anxiety disorder. MHPSS professionals need to clearly explain what they mean when they use such concepts in conversations with Rohingya clients. When interpreters from the community are used, it is important to ensure that the interpreters understand the concepts conveyed by the MHPSS worker.

Practitioners, both national and international, involved in mental health and psychosocial support programs for Rohingya refugees should make efforts to understand and explore their clients' cultural idioms of distress (common modes of expressing distress within a culture or community) and explanatory models (the ways that people explain and make sense of their symptoms or illness), which influence their expectations and coping strategies[198].

6.3 Help seeking behaviour

Rohingya are largely unfamiliar with the concepts and methods of international mental health and will tend to seek help for physical symptoms in the health centres or go to traditional healers when they feel their problem can better be addressed through spiritual healing. It is important that MHPSS programmes reach out to traditional and religious healers to understand their methods, provide them with information about MHPSS programmes, and foster collaborative links [161, 164].

6.4 Gender norms and SGBV

Culturally sanctioned norms and practices about gender roles and structural gender inequality within a traditionally patriarchal society remain a challenge in MHPSS services, particularly when addressing SGBV issues amongst Rohingya women and girls. For example, matching genders of MHPSS workers and their clients should be prioritized. If that is not feasible, it is important that MHPSS workers discuss with the woman how she feels most comfortable (e.g., if a male psychosocial worker sees a female client, she may feel uncomfortable with the doors and windows closed as this may fuel rumours). These safety/comfort concerns should be discussed with beneficiaries prior to initiating services. Psychosocial service providers should be specifically trained around SGBV, as there is a risk of reinforcing discriminative and oppressive structures in formalized services.

Globally, SGBV interventions addressing social norms show promise [199]. In Malaysia, a manual to raise awareness around intimate partner abuse has been developed specifically for Rohingya community members; associated awareness raising posters designed by community members have also been developed and tested [200].

6.5 Adaptation of materials

MHPSS programmes and activities for Rohingya should draw on past and existing work about the adaption of psychological assessment tools and treatments grounded in local terminology and culturally specific concepts of illness. This can facilitate community case detection and delivery of effective, culturally sensitive, and non-stigmatizing care for Rohingya. Materials for psychoeducation and manualized treatment protocols for scalable psychological interventions should be adapted to the Rohingya context, piloted before widespread implementation, and use appropriate language and examples.

6.6 MHPSS Settings

A major challenge is that the settings for MHPSS services in Bangladesh/Myanmar do often not guarantee confidentiality. When services are provided in makeshift health centres, community centres, informal spaces (e.g. household visits), MHPSS personnel should advocate for appropriate facilities and a separate consultation space and understand do no harm approaches and strategies to use when those facilities are not available (e.g., MHPSS workers should be trained to preserve confidentiality in these settings by lowering their voice).

6.7 Acknowledging diversity within Rohingya refugee populations

Globally, groups of Rohingya have migrated to various countries and their migration histories shape their identity. There is also considerable difference between Rohingya in the northern parts of Rakhine state and those in the central parts of the state. Rohingya refugees, should therefore not be considered a homogenous group. The mental health needs of Rohingya may differ more widely than what has been captured in this report. The current and existing literature available to date, does not allow for disaggregation of differing Rohingya sub-groups own unique needs and experiences.

7. CONCLUSION

The substantial emotional suffering and ongoing systematic discrimination against Rohingya refugees poses enormous challenges, and humanitarian staff can easily feel overwhelmed in the face of multiple needs. However, the current crisis also provides new resources and new opportunities to develop services and supports that are culturally relevant and contextually appropriate. Attention to past exposure to traumatic events and losses need to be paired with attention for ongoing stressors and issues related to worries about the future. It is important to design MHPSS interventions in ways that mobilize the individual and collective strengths of refugees and build on their resilience. This requires efforts from MHPSS workers to work *with* Rohingya refugees and not merely *for* them. A sound understanding of the ways in which Rohingya people conceptualize their suffering and work towards solutions is essential.

Appendix 1:

Search terms

String Search #	Search terms	Date of the search	Database/source	Number of total results	Number of potentially relevant results (title screening)	Number of results officially meeting inclusion criteria (abstract screening)
1	("Myanmar" OR "Burma" OR "Rakhine" OR "Bangladesh" OR "Malaysia" OR "India" OR "Thailand" OR "Asia" OR Refugee* OR Asylum Seeker* OR Displace* OR Rohingya*) **AND** ("Humanitarian" OR "Emergency" OR "Disaster" OR "Conflict" OR "War" OR "Violence" OR "Warfare" OR "Armed Conflict" OR "Mass Conflict" OR Persecut* OR "Civil Conflict" OR "Genocide" OR "Mass Murder" OR "Human Rights" OR "Ethnic Cleansing" OR "Mass Violence")	25/10/2017	CINAHL	3424	6	1
		23/10/2017	Cochrane	2289	18	0
		24/10/2017	PILOTS	1451	270	118
		23/10/2017	PsychInfo	161	17	3
		23/10/2017	PubMed/ Medline	57686	10	0
		25/10/2017	Scorpus	267	77	50
		24/10/2017	Web of Science	25587	98	34
		25/10/2017	WileyOnline	254	5	3
2	("Myanmar" OR "Burma" OR "Rakhine" OR "Bangladesh" OR "Malaysia" OR "India" OR "Thailand" OR "Asia" OR Refugee* OR Asylum Seeker* OR Displace* OR Rohingya*) **AND** ("Humanitarian" OR "Emergency" OR "Disaster" OR "Conflict" OR "War" OR "Violence" OR "Warfare" OR "Armed Conflict" OR "Mass Conflict" OR Persecut* OR "Civil Conflict" OR "Genocide" OR "Mass Murder" OR "Terrorism" OR "Human Rights" OR "Ethnic Cleansing" OR "Mass Violence") **OR** ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence")	25/10/2017	CINAHL	18714	11	9
		25/10/2017	Cochrane	3206	4	3
		24/10/2017	PILOTS	10912	198	63
		24/10/2017	PsychInfo	83	14	5
		24/10/2017	PubMed/ Medline	336	54	23
		25/10/2017	Scorpus	319	28	10
		24/10/2017	Web of Science	82735	106	4
		25/10/2017	WileyOnline	4925	16	12
3	("Myanmar" OR "Burma" OR "Rakhine" OR "Bangladesh" OR "Malaysia" OR "India" OR "Thailand" OR "Asia" OR Refugee* OR Asylum Seeker* OR Displace* OR Rohingya*) **AND** ("Humanitarian" OR "Emergency" OR "Disaster" OR "Conflict" OR "War" OR "Violence" OR "Warfare" OR "Armed Conflict" OR "Mass Conflict" OR Persecut* OR "Civil Conflict" OR "Genocide" OR "Mass Murder" OR "Terrorism" OR "Human Rights" OR "Ethnic Cleansing" OR "Mass Violence") **AND** (Demograph* OR Migrat* OR Histor* OR Politic* OR Religio* OR Econom* OR Livelihood OR Poverty OR Gender OR Family OR Tradition OR Ritual OR Health OR Disease)	25/10/2017	CINAHL	2521	6	5
		23/10/2017	Cochrane	2020	3	2
		23/10/2017	PILOTS	726	278	3
		24/10/2017	PsychInfo	376	109	39
		24/10/2017	PubMed/ Medline	25800	53	12
		25/10/2017	Scorpus	753	16	8
		24/10/2017	Web of Science	21903	246	56
		25/10/2017	WileyOnline	241	11	2

String Search #	Search terms	Date of the search	Database/source	Number of total results	Number of potentially relevant results (title screening)	Number of results officially meeting inclusion criteria (abstract screening)
4	("Myanmar" OR "Burma" OR "Rakhine" OR "Bangladesh" OR "Malaysia" OR "India" OR "Thailand" OR "Asia" OR Refugee* OR Asylum Seeker* OR Displace* OR Rohingya*) **AND** ("Humanitarian" OR "Emergency" OR "Disaster" OR "Conflict" OR "War" OR "Violence" OR "Warfare" OR "Armed Conflict" OR "Mass Conflict" OR Persecut* OR "Civil Conflict" OR "Genocide" OR "Mass Murder" OR "Terrorism" OR "Human Rights" OR "Ethnic Cleansing" OR "Mass Violence") **OR** ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence") **AND** (Demograph* OR Migrat* OR Histor* OR Politic* OR Religio* OR Econom* OR Livelihood OR Poverty OR Gender OR Family OR Tradition OR Ritual OR Health OR Disease)	25/10/2017	CINAHL	13027	13	8
		23/10/2017	Cochrane	2963	2	0
		25/10/2017	PILOTS	842	69	60
		24/10/2017	PsychInfo	5	1	0
		24/10/2017	PubMed/ Medline	270	52	0
		25/10/2017	Scorpus	4841	18	8
		24/10/2017	Web of Science	47452	230	16
		25/10/2017	WileyOnline	15600	5	2
5	("Myanmar" OR "Burma" OR "Rakhine" OR "Bangladesh" OR "Malaysia" OR "India" OR "Thailand" OR "Asia" OR Refugee* OR Asylum Seeker* OR Displace* OR Rohingya*) **AND** (Demograph* OR Migrat* OR Histor* OR Politic* OR Religio* OR Econom* OR Livelihood OR Poverty OR Gender OR Family OR Tradition OR Ritual OR Health OR Disease) **AND** ("Humanitarian" OR "Emergency" OR "Disaster" OR "Conflict" OR "War" OR "Violence" OR "Warfare" OR "Armed Conflict" OR "Mass Conflict" OR Persecut* OR "Civil Conflict" OR "Genocide" OR "Mass Murder" OR "Terrorism" OR "Human Rights" OR "Ethnic Cleansing" OR "Mass Violence") **AND** ("Mental health" OR "Mental disorder" OR "Psychological Disorder" OR "Psychiatric Disorder" OR Psychosocial OR Psychiatr* OR Wellbeing OR Distress OR Trauma OR Psychol* OR Functioning OR Depression OR Anxiety OR PTSD OR "Post-traumatic stress" OR Anger OR Grief OR Panic OR Separation Anxiety OR "Substance use" OR Stress OR Psychotic)	25/10/2017	CINAHL	1081	13	8
		23/10/2017	Cochrane	1431	1	0
		25/10/2017	PILOTS	3237	57	43
		24/10/2017	PsychInfo	0	0	0
		25/10/2017	PubMed/ Medline	40	8	2
		25/10/2017	Scorpus	7811	22	12
		24/10/2017	Web of Science	4853	37	2
		25/10/2017	WileyOnline	149	4	1

String Search #	Search terms	Date of the search	Database/source	Number of total results	Number of potentially relevant results (title screening)	Number of results officially meeting inclusion criteria (abstract screening)
6	("Myanmar" OR "Burma" OR "Rakhine" OR "Bangladesh" OR "Malaysia" OR "India" OR "Thailand" OR "Asia" OR Refugee* OR Asylum Seeker* OR Displace* OR Rohingya*) **AND** (Demograph* OR Migrat* OR Histor* OR Politic* OR Religio* OR Econom* OR Livelihood OR Poverty OR Gender OR Family OR Tradition OR Ritual OR Health OR Disease) **AND** ("Humanitarian" OR "Emergency" OR "Disaster" OR "Conflict" OR "War" OR "Violence" OR "Warfare" OR "Armed Conflict" OR "Mass Conflict" OR Persecut* OR "Civil Conflict" OR "Genocide" OR "Mass Murder" OR "Terrorism" OR "Human Rights" OR "Ethnic Cleansing" OR "Mass Violence") **OR** ("Gender-based violence" OR "Sexual violence" OR "Violence against women" OR Rape OR "Domestic violence" OR "Intimate partner violence") **AND** ("Mental health" OR "Mental disorder" OR "Psychological Disorder" OR "Psychiatric Disorder" OR Psychosocial OR Psychiatr* OR Wellbeing OR Distress OR Trauma OR Psychol* OR Functioning OR Depression OR Anxiety OR PTSD OR "Post-traumatic stress" OR Anger OR Grief OR Panic OR Separation Anxiety OR "Substance use" OR Stress OR Psychotic)	25/10/2017	CINAHL	9978	9	6
		23/10/2017	Cochrane	2661	0	0
		25/10/2017	PILOTS	711	16	8
		24/10/2017	PsychInfo	1	0	0
		25/10/2017	PubMed/ Medline	1551	18	7
		25/10/2017	Scorpus	7834	31	5
		24/10/2017	Web of Science	29507	413	10
		25/10/2017	WileyOnline	238	11	3
7	("Myanmar" OR "Burma" OR "Rakhine" OR "Bangladesh" OR "Malaysia" OR "India" OR "Thailand" OR "Asia" OR Refugee* OR Asylum Seeker* OR Displace* OR Rohingya*) AND (Demograph* OR Migrat* OR Histor* OR Politic* OR Religio* OR Econom* OR Livelihood OR Poverty OR Gender OR Family OR Tradition OR Ritual OR Health OR Disease) AND ("Humanitarian" OR "Emergency" OR "Disaster" OR "Conflict" OR "War" OR "Violence" OR "Warfare" OR "Armed Conflict" OR "Mass Conflict" OR Persecut* OR "Civil Conflict" OR "Genocide" OR "Mass Murder" OR "Terrorism" OR "Human Rights" OR "Ethnic Cleansing" OR "Mass Violence") AND (Demograph* OR Migrat* OR Histor* OR Politic* OR Religio* OR Econom* OR Livelihood OR Poverty OR Gender OR Family OR Tradition OR Ritual OR Health OR Disease) AND ("Mental health" OR "Mental disorder" OR "Psychological Disorder" OR "Psychiatric Disorder" OR Psychosocial OR Psychiatr* OR Wellbeing OR Distress OR Trauma OR Psychol* OR Functioning OR Depression OR Anxiety OR PTSD OR "Post-traumatic stress" OR Anger OR Grief OR Panic OR Separation Anxiety OR "Substance use" OR Stress OR Psychotic)	25/10/2017	CINAHL	1081	6	2
		23/10/2017	Cochrane	1431	1	0
		25/10/2017	PILOTS	3273	31	12
		24/10/2017	PsychInfo	0	0	0
		25/10/2017	PubMed/ Medline	17	10	6
		25/10/2017	Scorpus	7811	18	1
		24/10/2017	Web of Science	4071	49	0
		25/10/2017	WileyOnline	231	13	2

Appendix 2:

Overview of the political history of Myanmar with particular focus on Rohingya

Period	Events
8th century	Independent kingdom in Arakan, now known as Rakhine state in modern-day Myanmar.
9th to 14th century	People of Arakan come into contact with Islam through Arab traders. Close ties are forged between Arakan and Bengal.
1784	The Burman King Bodawpaya conquers Arakan.
1824 – 1942	Britain captures Burma – now known as Myanmar – and makes it a province of British India. Workers from other parts of British India migrate to Burma for infrastructure projects.
Early 1930s	Nationalist ideologies develop within Burmese Buddhists. Major riots take place targeting Indians, Chinese, and Muslims [201].
1942	Japan invades Burma, pushing out the British which leads to violence between Buddhists supported the Japanese and Muslims, many of whom were supportive of the British [10].
1942–1947	Many Muslims from Arakan flee into East Bengal [202].
1945	Britain retakes Burma from Japanese occupation with help of Burmese nationalists including Muslims (Rohingya). The British do not fulfil promises for autonomy for Arakan.
1948	Freedom from British rule is granted. Tensions increase between the government of the newly independent Burma and the Rohingya, many of whom wanted Arakan to join Muslim-majority Pakistan. The government retaliates by ostracizing Rohingya, including removing Rohingya civil servants.
1947	Some Rohingya armed groups called *Mujahids* push for an autonomous Muslim territory in Rakhine. A group of ethnic Rakhine intellectuals advocates for the creation of an independent "Arakanistan" for the Rakhine people [10].
1962–1974	General Ne Win and his Burma Socialist Programme Party seize power and take a hard line against the Rohingya [203, 204].
1967	ASEAN (Association of South-East Asian Nations) is formed. Myanmar does not join due to its 'hermit-like' political behaviour, socialist government, and internationally-recognized human rights abuses [202].
1974–1988	Burma Socialist Party (BSPP) is formed, completing Ne Win's vision of a one-party system in which he is the President [205].
1977	The military government begins Operation Nagamin, or Dragon King, aimed at screening the population for foreigners. More than 200,000 Rohingya flee to Bangladesh, amid allegations of army abuses [50].
1977–1978	A nationwide immigration and residence check is conducted government to remove Chinese and Bangladeshi foreigners. Approximately 200,000 Muslims are forced out of the country; after proving citizenship under the current law, almost all of them are repatriated [205].
1978	Bangladesh strikes a U.N.-brokered deal with Burma for the repatriation of refugees, under which most Rohingya return.
1982	A new immigration law redefines people who migrated during British rule as illegal immigrants. The government applies this to all Rohingya, leaving them stateless [206].
1988	Following years of protests and socioeconomic decline, Myanmar experiences a second military coup leading to the State Law and Order Restoration Council [205].
1989	The army changes the name of Burma to Myanmar.
1990	General elections are held with the National League for Democracy (NLD) winning 392 out of 492 seats; yet, the military maintains control. NLD leader, Aung San Suu Kyi, and other members are detained [202].
1990–1991	More than 250,000 Rohingya refugees flee to Bangladesh [207]
1992–1997	The governments of Myanmar and Bangladesh broker an agreement for voluntary return. Initially, few refugees opt for repatriation, but numbers increase when the camp conditions decline [207, 208]. Around 237,000 Rohingya return to Rakhine State. UNHCR maintains two camps in Cox's Bazar sheltering around 28,000 registered refugees. Hundreds of thousands of other 'unregistered' Rohingya remain in the Cox's Bazar area [205, 209].
1997	Myanmar joins ASEAN

Period	Events
2008	A major natural disaster, Cyclone Nargis, prompts the government to allow more foreign aid agencies to enter Myanmar.
2010	General election places Union Solidarity and Development Party (USDP) in power, led by President Thein Sein. The army (Tatmadaw), maintains control of important/ government institutions such as the Ministry of Home Affairs.
2012	Parliamentary by-elections are held. NLD wins majority seats and Aung San Suu Kyi is elected to Parliament.
2012	Riots between Rakhine Buddhists and Rohingya lead to dozens of deaths, mostly Rohingya. Nearly 150,000 are forced into IDP camps in Sittwe and surrounding areas [10]. Tens of thousands of people flee to Bangladesh.
2015	General elections held and NLD wins by a landslide [205].
2016	Rohingya militant group Harakah al-Yaqin (currently known as ARSA) attacks border guard posts, killing nine soldiers. The army retaliates. Around 90,000 refugees flee Rakhine to Bangladesh [54]. Refugees report killing, rape and arson. Aung San Suu Kyi's government denies the atrocities [39].
2017	In August 2017, an attack by Rohingya militants sparks widespread violence against Rohingya in Northern Rakhine State which leads to the displacement of almost ¾ million Rohingya refugees to Bangladesh [4, 54].

Appendix 3:

Overview of mental health epidemiology amongst Rohingya refugees

Mental health problems	Sub-group	Setting and time point	Prevalence	Risk factors	Protective factors
Depression	General refugee population [139]	Tal camp Nayapara camp Kutupalong camp Bangladesh (2006)	N/A – qualitative field observation	Breakdown in social mores and traditions; lack of activities, stimulation and support in camps; unaddressed maladaptive coping strategies; cultural stigma about mental health, lack of understanding	Motivation and optimism about future; spiritual adherence and practice
	Adult refugee population [90]	Kutupalong and Nayapara refugee camps – Bangladesh (2013 Over a 2 month period)	89%	Sex/gender (female), older age, daily environmental stressors	Social support
PTSD	Adult refugee population [90]	Kutupalong and Nayapara refugee camps Bangladesh (2013)	36%	Lack of food security; lack of freedom of movement; lack of fair access to services; sex/gender (female); older age; daily environmental stressors; trauma exposure	Social support
Anxiety-like symptoms	Adult refugee population [90]	Kutupalong and Nayapara refugee camps –, Bangladesh (2013)	14%	Not included in the analysis	Not included in the analysis
Explosive anger	Adult refugee population [90]	as above (2013)	9%	Not included in the analysis	Not included in the analysis
Somatic/ medically unexplained symptoms	Adult refugee population [90]	as above (2013)	49%--67%	Not included in the analysis	Not included in the analysis
Psychotic-like symptoms	Adult refugee population [90]	as above	2–5%	Not included in the analysis	Not included in the analysis
Suicidal ideation	Adult refugee population [90]	Kutupalong and Nayapara refugee camps Bangladesh (2013)	13%	Sex/gender (female), older age, daily environmental stressors	Social support
	Population who received psychosocial evaluation [151]	Northern Rakhine State January (2015 – March 2016)	52%		

Appendix 4:

Rohingya/Ruáingga terminology related to mental health

This table of Rohingya terminology was made with input from a consultation group comprising Rohingya religious leaders, community leaders, members, and scholars from Myanmar, Malaysia, and Bangladesh. Particular thanks go to M.S. Anwar, Rafiqul Islam, and Mahmuda.

	English descriptions	Rohingya terminology	
		Core terms	Synonyms/equivalents
1.	Abandonment	*félai-zón*	*félai-dón, thon-hyéi, chúçí- dón*
2.	Accuse	*Baazá*	*elzaam-de, khosúrr-dé*
3.	Adjustment	*ét-mét-bágón*	*háçéfan/munaséf-óufá-gorón*
4.	Affection	*shóu-fó-khót*	*ador-doiya/rahám-dóiya, XXX*
5.	Aggressiveness	*Gáarái*	*gét-oun/gécái/gua-rai, fúzí-hojje XX*
6.	Agoraphobia	*ejelás-chúrái*	*nema-turai, miljúl-nogorá, bér-khúló, doron*
7.	Alarm	*húshiyár-gori-don*	*sethon-gori-don, ehou-khonna, toçob*
8.	Alertness	*húshiyár-tagón*	*húshiyári,chúçáal-thagon/óun,zerok*
9.	Alone	*Háligá, gaga*	*gaaga, ekélá, thonhá, fúaijja-sard*
10.	Anger	*Guishá*	*Bezaar*
11.	Anxious	*Ba-fa-seintaat*	*Dilor-todob-fot/ba-fa-naat = (ase)*
12.	anxiety	*Ba-fa-seinta*	*Dilor-fikirr/tocob/ba-fa-na*
13.	Apathy	*Befikirr/bette-sha*	*Dil-nowuzon, dilot/nogolon, be-agot, be-mahasns, be-gour*
14.	Attachment (brotherhood)	*Zaathi-tain*	*Khunor-tain, khaomi-dorot, taatsubiyet*
15.	Attachment (feeling)	*Soumaji-tan*	*Miliguli-fuathi-thaga-ette-faaki-ettahadi*
16.	Attention	*Kheyaal-rakhon*	*Kheyaal/diyaan-nozor-don, saasita*
17.	Attitude	*Nozoraan, hassa*	*(dilor)-monsha/buz/dekha, shai, forzon*
18.	Avoid	*Hari-thagae*	*Basi-thagae, eraas, choun-gore*
19.	Bad luck	*Baiggou-horaaf*	*Bouth-kismot, kuaal-horaaf*
20.	Behaviour	*Haslot*	*Adot-haslot, thour-thorika, obaagoth*
21.	Belief	*Bijchaij*	*Etekhaat, (dilor)=buz/mana/youkein*
22.	Belonging (family)	*Egaena-guijshi*	*guijshi -baradhi*
23.	Belonging (utensils)	*Desshi fatila*	*Don-chom-bouthi/maal-don (……*
24.	Big forehead	*Borr-kuailla/li*	*Kuaal-boulon, baigg……*
25.	Bitter	*(dil/mon)=thita*	*Sho-thita-zoher-thita, mojus…*
26.	Blame	*Khsuri-de*	*Ehekhayet-jose/de, guari-g…*
27.	Bothered	*Jamila-gore*	*Kholof-de, dil-peseshan-gore, ….*
28.	Boredom	*Dil-okthon*	*Gom-no-lagon, mone-no-houn*
29.	Broken forehead	*Kuaal-fadea*	*Raea-khailla/li, houth-nosibi/kiemets*
30.	Comfortable	*Araam*	*Araamor, araam-lager/olye*
31.	Concentration	*Diyan-don/diya*	*Eksuyee, ek-mon-ek-duyon*
32.	Concern	*Fekirr*	*Taaluk, zururot*
33.	Conflict	*Fo-saat*	*Nozoriya-forok-oun, …..*
34.	Confuse	*Chiak-biak*	*Tomies-gori-no-fare*
35.	Confusion	*Chiak-biak-oum*	*Tomie-gori-no-foron*

	English descriptions	Rohingya terminology	
		Core terms	Synonyms/equivalents
36.	Control	*Somale*	*Khaaba-gose*
37.	Counselling	*Mochowara-gori-tosoulli-don*	*Etminaam-don, moch….*
38.	Cope	*Houl-gore*	*(moj-khil) houl-gose……*
39.	Craziness	*Bekufi*	*Mojuna, foulai*
40.	Darkness	*Andorr-lagon*	*Andera*
41.	Depressed	*Dilor-joshba-home*	*Dil/mon-bor, ra…..*
42.	Depression (nothing left)	*Na-ommaide/durkuita-zindegi*	*Behsusila, besdora, ashasa'ra, dockorr, zindesgi….*
43.	Depression (statelessness)	*deshór – oshántí*	*deshór-síntá*
44.	depression (family)	*gor-barir-sinta*	*gor-barir-báb*
45.	detachment	*Taa-luk-ceri-fèlon*	*dili-judaiyee, tan-no-tágon*
46.	disadvantage	*Khom-zuri*	*hámi, gunári, ochúbeda*
47.	disappointment	*dil-bezaar-oum*	*mon-horaf-oun*
48.	disaster	*aforth, bawlar mosiboth*	*aforth-bola, hóutóura*
49.	Disbelief	*na-bysháshi*	*etekhaat-no-tágon*
50.	Discriminate	*forók-góré*	*forók-góré-borr-ta-oo-goron*
51.	Discomfort	*(Dil)becháin/hosara*	*aram-no-lágon*
52.	Disgust	*nefórot*	*dhei-no-fáron, choc-lágon*
53.	Displacement	*outhón-sáron*	*outhón-sáráboun, larai-félon*
54.	Distraction	*dhiyan-lárai-félon*	*zehén-lori-zon, entesharr*
55.	Distress	*(dilor)doc-toko-lib*	*(dilor) oúshu-beda, aforth, doc*
56.	Disorder	*(dilor)oshúk*	*(dilor)oushú-beda, be-muzu*
57.	Disturbance	*disturb-don*	*hólol-don,dil-pereshan-goron*
58.	Disruption	*bé-záal-goron*	*bóuñthi-góron*
59.	Dizziness	*matá-góron*	
60.	Ego	*Khút-góros*	*(dilor) gorós*
61.	Emotion	*dili-háláat*	*(dilor)guzaraan*
62.	Empathy	*tokolib-buzi-don*	*mosh-khil-buzi-fára*
63.	Emptiness	*háilla*	*haili(zéhen)/haili(dil)*
64.	Expression of sadness	*aha/ohu*	*ooh/hai/hairee*
65.	Faint	*behoñj*	*súu-hára*
66.	Faith	*you-kiin*	*emaan, beish-cháij*
67.	Fatigue	*oran-péreshan*	*(dil) hóran*
68.	Fear	*Dorr*	
69.	Fearful (being killed)	*Dorr-laga*	
70.	Feeling	*(dolor/gaar)*	*Afor, esass*
71.	Forgetting	*Forai-zon*	*Forai-felon*
72.	Forehead bad	*Kual-horaf*	*Toukdir-horaf*
73.	Forehead opened	*Kual-bolon-oiye*	*Zindegi-bodoile*
74.	Frustration	*Diler-bol/nofon*	*Dil-ouk-ton, etminan-ne-oum*
75.	Good, well	*Gom*	*Bala-behe-thbur*
76.	Grief	*Dilor-furani*	*Eydali-ocon*
77.	Guilt	*(dili) dhush*	*Khosur, khosuri*
78.	Happiness	*Khushi*	*Khushi-lagon*
79.	Happy door open	*Khushir-time-aijje*	*Ghuk-ghantir-time-fonjje*
80.	Harmony	*Bo-ni-et*	*Ettechad*

	English descriptions	Rohingya terminology	
		Core terms	Synonyms/equivalents
81.	Helplessness	*Besa-rah*	*Bewacila*
82.	Homesickness	*Gorola-dil-jolor*	*Goror-furani/yaat-giri, doshor-furani*
83.	Hope	*Asha-ommaid*	
84.	Hopeless	*Asha-bara*	*Na-ommaid*
85.	Hopeless (Refugee status)	*Na-ommaid*	*Hono-asha-nai*
86.	Hopeless (Separation)	*Arr-horite-loi-jer*	*Hoce-bi-jer, arar-bonte-zai….*
87.	Horror	*Beneyomor-dorr*	*Neforot, naposoun*
88.	Humiliate	*Ochor-mani-gore*	*Shorom-diye, zolil-gore, beijzet-gore*
89.	Hostility	*HoijarOmonsha*	*Hoijjar-niyet, hoigj-tua*
90.	Hyperventilation	*Niyag-gore-oun*	*Niyaij-bari-oun*
91.	Hypervigilance	*Ocorr-hushi-yari*	*Be-niyomor-hushi-yari*
92.	Influence	*Asor-goron*	*Asor, pawar-solon*
93.	Insensitivity	*Behefazot*	*Dilor-togobi, hefazot-sasa*
94.	Isolation (separated)	*Judaiyee*	*BhairOgoridon, aleg/sera*
95.	Isolation (alone)	…..	*Judaiyee*
96.	Sleep	*Gim*	
97.	Insult	*Dairtte*	*Beizzot-gore, esteheza*
98.	Interest	*Dil-chojfi*	*Dil-tuaigu, arzu*
99.	Inspiration	*Joshba-don*	*Dili-boul-don*
100.	Instinct	*Zaat-dora*	*Kudu-niti-dwara, ounokgene*
101.	Irritability	*Arojsha-oun*	*Bechaim, ku-sail-goron*
102.	Isolation	*Thonhaiyee, haligaa*	*Judaiyee*
103.	Jealous	*Hazawrawt*	*Bukzou, aling*
104.	Joy	*Khushi*	
105.	Jumpiness	*Choit-goron*	*Gokun-sara, bechain, bekeraar*
106.	Loneliness	*Thon-haryee*	
107.	Loneliness (not with family)	*Judinyee*	*Khaliga*
108.	Loneliness	*Gaaga*	*Than-haigee*
109.	Lonely	*Ekhala*	*Thon-ha, thone-thonha*
110.	Lost	*Hountte*	*Ainjie, haraige, hoimme*
111.	Lost (materials)	*Azi-giyoi*	
112.	Lost (family)	*Haráiyé*	*Hárai-feláiyeé*
113.	Lost (interest)	*Dil-chojfi-ho-mi-giyoi*	*Dil-tuajo-homi-giyoi*
114.	Love	*Adorr*	*Muhábbóth*
115.	Lovely	*Adojja*	*Chuñ-dojja*
116.	Luck already come back	*Baiggou-firje*	*Zindegi-firje*
117.	Madness	*Foul-oun*	*Foulai/dil-demaki-khomsuri*
118.	Mechanism	*Surót/torikha*	*(sorlo-vor) súrot, oosule-zabéta*
119.	Meditation	*Dhiyanot-bóyon*	*Eté-kup-bóyon*
120.	Memory	*Monót-tága*	*Yaat-tága, haféza*
121.	Mental health	*Dilor-ara-miyot*	*Dilor-sehét, ruhani-ara-miyot*
122.	Mind	*Dil/mon*	*Dil-demag*
123.	Motivation	*Dili-dháf*	*Dil-tuáijjo/monsha*
124.	Nausea	*Waijshon*	*Wolani-aiyón*
125.	Nervous	*Dordor-lage*	*Himmot-bhañ-gizon*

	English descriptions	Rohingya terminology	
		Core terms	Synonyms/equivalents
126.	Nightmare	*Horáf kuáp*	*Horáf shoppón*
127.	No end of sufferings	*Ofúsani-doc*	*Doc-no-furaibo/no-sáribo*
128.	No peace at house	*Gorór-óuchanti*	*Gor-bárit-chanti-nai*
129.	Not feeling well	*Gom-no-láger*	*Chanti-no-láger*
130.	Now is comfortable	*Ahon-aram-ací*	*Ahon-chanti-láger*
131.	Now not suffering	*Ahon-dokot-nai*	*Ahon-tic-acé/aram-aci*
132.	Numbness	*Besút*	
133.	Optimism	*Bála-gúmáan*	*Bála-acha/ommaid, gom-acha*
134.	Palpitation	*Khoilla-dudo-fani*	
135.	Pain in the body	*gaa-bij*	
136.	Peace is at home	*Gorot-chánthi*	*Chántir-girosci*
137.	Peace is inside (heart)	*Dil-mon chánti*	*Monot chanti*
138.	Perception	*(dilor) buzá*	*Dilor-dhekha*
139.	Personality	*Hásolot*	
140.	Pleasure	*Aiyashi-khushi*	*Soukun, etminan*
141.	Posture	*(gaa) dekha deya*	*Khai-am*
142.	Psychosocial	*Dilor-miljulor-bawate*	
143.	Predictability	*Antaz-gori-fára*	*Khiyas-gori-fára*
144.	Predisposition	*Shokol/ala-mot*	*Súrot*
145.	Pressure	*Ceeb*	*Precharr, ceeb-don*
146.	Problems	*Gou-tou-na*	*Mosibat- fitena*
147.	Procrastination	*Desi-goron*	*Tha-ha-rir-goron*
148.	Projection	*Dilor-dekha*	*Dilor-antazi*
149.	Regression	*(hato) fissa-zon*	*(halot) goti-zon*
150.	Reaction	*(dubara) aasor*	*Wapes-gorá*
151.	Relaxation	*Horan-khaçon*	*Aram-goron, zerai-horan-kha-çon*
152.	Reliving	*Dubara-monot-wu-çon*	*Wa-pes-esaas-oun*
153.	Reluctant	*Moné-noho*	
154.	Remembrance	*Monot-foron*	*Monnot-wuçon*
155.	Reminder	*Yaad-dalon*	*Monot-gori-don, táar-tuli-don*
156.	Repression	*Ce-bi-ra-kon*	*Chupai-ra-kon, zulom séta*
157.	Resilience	*Bor-daij-tou*	
158.	Restlessness	*Chóit-goron*	*Becháin, bekerari, be-etmi-nani*
159.	Sadness	*Peré-chani*	*Ou-chanti*
160.	Sadness (lack of needs)	*Dukh/dukhita*	*Ba-fa-na*
161.	Sadness (lack of home)	*Sein-taat*	*Dukhot*
162.	Safe (family)	*Etminan*	*Héfa-zot*
163.	Feared	*Dorr-lagé*	
164.	Sensation	*(gaar) esaas*	*Maha-sus-goron*
165.	Sensitivity	*Jolti-buzi-faron*	*Esaas-gori-fárá*
166.	Separate	*Alog/séra-gore*	*Juda-goré*
167.	Shake	*Záara*	*Hafé*
168.	Shame	*Chorom*	*Haiya*
169.	Shock	*Dilot-do-ron*	
170.	Sighing	*Bor-niáÿ*	*Ouchantir-niáÿ*

	English descriptions	Rohingya terminology	
		Core terms	Synonyms/equivalents
171.	Sorrow	*Afsus*	
172.	Soul is big	*Dil-dor*	*Bor-foran, foranot-faniáÿjé*
173.	Spirit	*Háki-ki*	*Báteni/rohani/dili*
174.	Stimulation	*Hao-sala-don*	*(dili) bol-don*
175.	Stress	*Dili-tosho-wij*	*Pora-gonda, dili-ceeb/fekis*
176.	Stuck	*Bazi/bon-ou-ta-gon*	*Ek-jagat-tiyai-zon-goi*
177.	Stunned	*Besúth/behush*	*Taaijjub, taçal-haiya*
178.	Substance/drug use	*Nesha-fani-es-te-maal*	*Substance/drug use*
179.	Suffering in forehead	*Kualor-dhukh*	
180.	Suffering (Eating)	*Haiti-loiti-dhukh*	*Sola-fira-dhukhot*
181.	Suicide	*Khut-khushi*	*Nizor-foran-nize-don*
182.	Surprise	*Taaijub*	
183.	Sympathy	*Raham*	*Raham-khoram*
184.	Temperament	*Dilor boal*	*Dili-télaam*
185.	Tendency	*Dili-roja-han*	*Dil-zon*
186.	Tension	*Dilor-shiac*	*Dili-holol*
187.	Thought	*Báaf*	*Ba-fa, vafani*
188.	Threat	*Domki*	
189.	Threaten	*Dhoñklágá*	*Dhonki déyé*
190.	Tired	*Ho-ran ouyé*	
191.	Trauma	*Dilor sénaák*	*Dili-zokhom*
192.	Traditional healer	*Sáas-tori-alaish-goron-ya*	*Rosoumi-dabai-goro-ya*
193.	Tremor	*Hofon*	*Hafani*
194.	Trouble	*Tokolib/dhok*	*Céta*
195.	Trouble maker	*Tokolib/doiya*	*Cétouya*
196.	Trust	*Beshaÿ*	*Ete-barr*
197.	Uncertain	*óuibe-nouibo-hoi-nofaré*	*Tozu-zu*
198.	Unconsciousness	*Be-hush-won*	*Súharaiya, unjan*
199.	Uneasy	*Asaan-nai*	*Bekeraar*
200.	Unsafe	*Hefazot-sará*	*Hefazot-nai*
201.	Upset	*Mon-horáf*	*Monot-doc-lagé*
202.	Urges	*Dilor-josh*	*Dilor-telaan*
203.	Valueless	*Be-kimoti*	*Be-khaar*
204.	Vivid	*Haça-seça*	*Dilé dilé monot-foron, saf-sáf*
205.	Well	*Bála, gom*	*áisha*
206.	Worry and anxiety (lack of citizenship)	*Báfa-seinta*	*Seinta-fikir*
207.	Worthlessness/vileness	*Be-khar*	*Be-ha-zorr*
208.	Yelled	*Gu-zoz-jé*	
209.	Intellectual disability	*Zehéni-khom-zuri*	*Dil-demagi-khom-zuri*

Appendix 5:

Rohingya/Ruáingga terminology related to severe mental disorders

	English terms	Rohingya terms
1.	Agitation	*aasu-hásn, choitçe-goçe*
2.	Amnesia	*demag-tig-nai*
3.	Anesthesia	*besúd, bekhúd*
4.	Bewilderment	*tomis-gori-noforon, buzi-nofaron*
5.	Burn-out	*hyráam*
6.	Coma	*behoñj, súu*
7.	Delirium	*obbia, bibbia*
8.	Delusion	*aasu-hasa-tára*
9.	Dementia	*fóu-rósh*
10.	Epilepsy	*choa-fera, kézarai, asa-hasn*
11.	Flashback	*dhubasa-mont-foron*
12.	Frozen	*chil-haiya, aça-rod-hanga*
13.	Hallucination	*aasu-hásu-dheka*
14.	Hyper-tension	*naké-muké-zokgoilé*
15.	Hypervigilance	*béniyomor-touçob*
16.	Insomnia	*homot-hóulol-oum*
17.	Intellectual /cognitive disorder	*demagi-khomzari*
18.	Irritability	*aroushja*
19.	Mania	*demag-chóuf/horáf, soudou*
20.	Mental disorder	*demagi-khomzuri*
21.	Nightmare	*horáf-kuab*
22.	Psychosis	*foul, matá-horáf*
23.	Regression	*fissa-góuton*
24.	Repression	*mozai-rakom*
25.	Seizure	*demagi-betig-oum, asa-hasn*

Appendix 6:

Rohingya/Ruáingga terminology related to intellectual and developmental disabilities

	English terms	Rohingya terms
1.	Intellectual	*zéhni, demagi, akhóuli*
2.	Developmental	*torrki, baráah*
3.	Disability	*khomzuri, haami, mazur*
4.	Retardation	*fissá-tágá, fissá-forá/góutá*
5.	Dull/silly	*bekub, bedhom, khundóu-zehér*
6.	Less intelligent	*demag-khom, akhol-khom*
7.	Less memory	*haféza-khom*
8.	Stammer	*thúta, hotá-bazé*
9.	Pre-mature birth	*aat-dinna*
10.	Dumbness	*bouk*
11.	Deafness	*náa-fáang*
12.	Lameness	*aathurr*
13.	Madness	*foul, faagol, matá-horáf*
14.	Blindness	*aandhá*
15.	Stunting	*gáe-chéittá*
16.	Paralysis	*lula*
17.	Skinny	*khena, léça*
18.	Low understanding	*oubous*
19.	Developmental delay	*torrki-khom, baraah-hom*
20.	Speech delay	*maat-fuça-desi*
21.	Traumatic brain injury	*demagi-zokhom*
22.	Dementia	*fóurouj*
23.	Light-headed	*mata-háalkha*
24.	Physically handicap	*jismani-khomzuri*
25.	Mentally handicap	*demagi-khomzuri*

Appendix 7:

Rohingya/Ruáingga terminology related to gender and intimate partner violence

	Terminology in English	Translation in Rohingya (based on Roman script)	Written in Rohingyalish
1	Intimate Partner Abuse/Violence	*Haam Saati Saate Bura Taalukat (Zulum) [Hoshom/ Bivi, (Beda/Bedi) Maaze Bura Taalukat (Zulum)]*	*Hám Sati Sáté Bura Talukat (Zulúm) [Hocóm/ Bivi, (Beça/Beçi) Mazé Bura Talukat (Zulúm)]*
2	Husband/Wife	*Hoshom/Bivi (Beda/Bedi)*	*Hocóm/Bivi (Beça/Beçi)*
3	Mental Health	*Demaagi Sehet (Demagor Haalot)*	*Demagi Sehét (Demagor Hálót)*
4	Social Norms	*Somaji Tarika (Riwaaj)*	*Sómájí Torika (Riwaj)*
5	Human Right	*Insaani Hoque*	*Insáni Hóq*
6	Attitude	*Aadov Hasalot*	*Aadov Hásolót*
7	Intention/Behaviour	*Eraada/Haasolot*	*Erada/Hásolót*
8	Habit	*Haassa*	*Hássá*
9	Social Cohesion	*Somaji Mil Milaat*	*Sómájí Mil Milat*
10	Efficacy	*Taaqat (Aasha Gori Raik Kede Hiyaan Haasil Gori Faaronor TAAQAT)*	*Taqot (Aacá Gorí Raík Kédé Híyán Hásíl Gorí Faronor TAQOT)*
11	Capacity	*Taaqat (Hono Kesso Gori Faaronor TAAQAT)*	*Taqot (Honó Kessú Gorí Faronor Taqot)*
12	Stress/Stressor/Stress Management	*Pareshani Haalot/Pareshani Gorode Sheez/ Pareshaani Uddhar Goronor Torika*	*Perecani Hàlót/Perecani Gorédé Ceez/ Perecani Uddár Gorónór Torika*
13	Gender Role	*Beda'in Ya Bedi'yan Dor Zimmadari (Morod/Mayar Zimmadari)*	*Bedáin Yá Beçiyáin Dor Zimmadari (Moród/ Mayar Zimmadari)*
14	Relationship Conflict	*Taalukator (Rishtaar) Aanbon (Hojja)*	*Talukator (Rictar) Anbon (Hojja)*
15	Opinion/Belief	*Nasdik/Yekeen*	*Nosdík/Yekin*
16	Criticism	*Bala Bura Hon*	*Balá Búrá Hón*
17	Insult/Humiliation	*Bezzati/Sharam Doun*	*Beizzoutí/Córóm Doún*
18	Confidentiality	*Ra'azi Maamla (Hota), Butoror Maamla (Hota)*	*Rází Mamela (Hotá), Bútórór Mamela (Hotá)*
19	Psychosocial	*Somajor zoriya okkol aadde, ek zon ek zonor baafa aar, haasolotor maaze taalukaat aasedey, hiyanor baabotey.*	*Sómájór Zoriya Okkól Adde, Ek Zon Ek Zonor Báfá Ar, Hásolotór Mazé Talukat Asédé, Híyanór Bábote*
20	Fear	*Dorr*	*Dorr*
21	Anxiety	*Sintaa Mehsoos Goron*	*Sinta Méhsús Gorón*
22	Nervousness	*Tora Tori Aushaanti Sintaa Aun*	*Tora Tori Ocaántí Sinta Ón*
23	Depression/ Hopelessness	*Bishi Aushaanti Parenshaani Haalotot Foron/Aashaa Saraa Oi Zon Goi*	*Bici Ocaántí Perecaani Halótót Foron/Aacá Sára Ói Zon Gói*
24	Somatic	*Jisimor/Jismani*	*Jisímór/Jismani*
25	Irritability	*Tora Tori Aushaanti Aun*	*Tora Turi Ocaántí Ón*
26	Guilt/Self-Blame	*Hosuri/Nizer-Nizer Hosuri*	*Hosúrí/Nizer Nizer Hosúrí*
27	Sexual Abuse	*Bolotkaar/Izzator Worey Haat Daalon/Zulum Goron*	*Bolótkar/Izzótor Worey Haat Dalón/Zulúm Gorón*
28	Reproductive	*Fuwa'in-Bachcha Lonor Baabote*	*Fuwáin Bacca Lonor Babote*
29	Suicidality	*Hoodhushi Gora*	*Húdhúcí Gorá*
30	Social Isolation	*Somaj Loi Aalog Aun*	*Sómáj Lói Alóg Ón*
31	Biological Sex	*Jismani Modda/Maya*	*(Jismaani) Modda/Maya*
32	Displacement	*Beghar Bebaari Aun*	*Begór Bebari Ón*
33	Perpetrator	*Hosuri Goroya*	*Hosúrí Goróyá*
34	Stigmatize	*Buraa/Horaaf Manon*	*Bura/Hóráf Manon*
35	Community	*Samaj/Toular (Elaakaar) Maanuj*	*Sómáj/Thoular (Elaakaar) Maanúj*

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