The culture, mental health and psychosocial wellbeing of Rohingya refugees: a systematic review

Author for correspondence:
Alvin Kuowei Tay, E-mail:
alvin.tay@unsw.edu.au

A. K. Tay[1], A. Riley[2], R. Islam[2], C. Welton-Mitchell[3,4], B. Duchesne[2], V. Waters[5], A. Varner[6], B. Moussa[1], A. N. M. Mahmudul Alam[7], M. A. Elshazly[7], D. Silove[1] and P. Ventevogel[8]

[1]School of Psychiatry, University of New South Wales, Psychiatry Research and Teaching Unit, Academic Mental Health Unit, Liverpool Hospital, Sydney, Australia; [2]Independent consultant; [3]Institute of Behavioural Science, University of Colorado, Boulder, USA; [4]Environmental and Occupational Health, Public Health Preparedness and Disaster Response, Colorado School of Public Health, Aurora, CO, USA; [5]Danish Refugee Council, Cox's Bazar, Bangladesh; [6]World Concern, Seattle, WA, USA; [7]Mental Health & Psychosocial Support Team, Public Health & Nutrition Unit, United Nations High Commissioner for Refugees, Cox's Bazar, Bangladesh and [8]Public Health Section, United Nations High Commissioner for Refugees, Geneva, Switzerland

Abstract

Aims. Despite the magnitude and protracted nature of the Rohingya refugee situation, there is limited information on the culture, mental health and psychosocial wellbeing of this group. This paper, drawing on a report commissioned by the United Nations High Commissioner for Refugees (UNHCR), aims to provide a comprehensive synthesis of the literature on mental health and psychosocial wellbeing of Rohingya refugees, including an examination of associated cultural factors. The ultimate objective is to assist humanitarian actors and agencies in providing culturally relevant Mental Health and Psychosocial Support (MHPSS) for Rohingya refugees displaced to Bangladesh and other neighbouring countries.

Methods. We conducted a systematic search across multiple sources of information with reference to the contextual, social, economic, cultural, mental health and health-related factors amongst Rohingya refugees living in the Asia-Pacific and other regions. The search covered online databases of diverse disciplines (e.g. medicine, psychology, anthropology), grey literature, as well as unpublished reports from non-profit organisations and United Nations agencies published until 2018.

Results. The legacy of prolonged exposure to conflict and persecution compounded by protracted conditions of deprivations and displacement is likely to increase the refugees' vulnerability to wide array of mental health problems including posttraumatic stress disorder, anxiety, depression and suicidal ideation. High rates of sexual and gender-based violence, lack of privacy and safe spaces and limited access to integrated psychosocial and mental health support remain issues of concern within the emergency operation in Bangladesh. Another challenge is the limited understanding amongst the MHPSS personnel in Bangladesh and elsewhere of the language, culture and help-seeking behaviour of Rohingya refugees. While the Rohingya language has a considerable vocabulary for emotional and behavioural problems, there is limited correspondence between these Rohingya terms and western concepts of mental disorders. This hampers the provision of culturally sensitive and contextually relevant MHPSS services to these refugees.

Conclusions. The knowledge about the culture, context, migration history, idioms of distress, help-seeking behaviour and traditional healing methods, obtained from diverse sources can be applied in the design and delivery of culturally appropriate interventions. 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 mobilise the individual and collective strengths of Rohingya refugees and build on their resilience.

CAMBRIDGE UNIVERSITY PRESS

Introduction

The Rohingya, an ethnic minority in the Rakhine State of Myanmar, have a long history of exposure to human rights violations and systematic discrimination, which over the past few decades has led to repeated cycles of forced displacement between Myanmar, Bangladesh and other neighbouring South East Asian countries. In August 2017, the Myanmar army commenced a massive clearance operation during which Rohingya homes and villages were systematically burnt down and thousands were killed by violence (Amnesty International, 2017; International Crisis Group, 2017; Darusman, 2018). These events prompted an

unprecedented exodus of around 750 000 Rohingya refugees to Cox's Bazar District in Bangladesh, causing a major humanitarian emergency that gravely compounded the existing challenges in the provision of assistance to the estimated 200 000 to 300 000 Rohingya refugees who were already in the country.

As yet, however, a key challenge to providing appropriate services for this population is the dearth of information concerning the mental health and associated cultural considerations of Rohingya, including those living under protracted conditions of displacement in Bangladesh and other countries (van Waas, 2010; Kiragu *et al.*, 2011; United Nations High Commissioner for Refugees, 2017). Drawing on a report commissioned by the United Nations High Commissioner for Refugees (UNHCR) (Tay *et al.*, 2018), this review aims to provide a comprehensive synthesis of the literature on mental health and psychosocial wellbeing of Rohingya refugees, including an examination of associated cultural factors. The ultimate objective is to assist humanitarian actors and agencies in providing culturally relevant Mental Health and Psychosocial Support (MHPSS) for this group.

Prior to 2017, Rakhine State was home to around 1.2 million Rohingya. Roughly two-thirds of them resided in three northern townships of the state: Maungdaw, Buthidaung and Rathedaung (Yethedaung) (United Nations High Commissioner for Refugees, 2010). Rohingya were the majority ethnic group in Maungdaw and Buthidaung, the only townships in Myanmar with a majority Muslim population.

In the period leading from independence (1948) to the military coup (1962), Rohingya had full citizenship rights, and could serve in Parliament (Parnini, 2013; Lee, 2014). The ensuing decades of military rule saw the gradual derogation of Rohingya's civil, political, educational and economic rights (Rogers, 2012). The 1982 Citizenship Act excluded the Rohingya from the list of officially recognised ethnic minorities and denied them many basic rights including citizenship, freedom of movement, access to healthcare and education, marital registration and the ability to vote (Human Rights Watch, 2009). This effectively rendered the Rohingya the largest stateless group in the world. In recent years, Buddhist extremist groups have provoked anti-Muslim sentiments, by supporting systematic campaigns of violence and discrimination against Rohingya (Holliday, 2014; Wade, 2017).

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, with small numbers found in Nepal, Thailand and Indonesia (Grønlund, 2016; Thom, 2016; United Nations High Commissioner for Refugees, 2017). None of these countries are party to the 1951 Refugee Convention or 1967 Protocol, which poses challenges to efforts to ensure 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. Numerous reports document the challenges facing Rohingya refugees living in Bangladesh, including restricted access to justice systems, healthcare, education and livelihood opportunities (Sullivan, 2018; US Department of State, 2018). An additional source of stress has been the development of bilateral agreements to repatriate Rohingya to Myanmar or relocate them to a remote island in Bangladesh (BenarNews, 2018; International Crisis Group, 2018).

Despite the magnitude and protracted nature of the Rohingya refugee situation, there is limited information on their mental health and associated cultural factors. Hence, the key objectives of this review are to: (1) provide a descriptive overview of the mental health and psychosocial wellbeing of Rohingya refugees; (2) summarise the salient local terminology used to describe mental health and psychosocial problems; (3) outline the use of traditional healing methods in addressing these problems and (4) highlight the challenges in the delivery of contextually and culturally appropriate MHPSS services for this population.

Methods

We conducted a comprehensive desk review using the World Health Organization (WHO)-UNHCR toolkit for assessing MHPSS needs and resources (World Health Organization and United Nations High Commissioner for Refugees, 2012). The search strategy included any relevant sources (published until 2018) with reference to the contextual, social, economic, cultural, mental health and health-related factors among Rohingya refugees living in the Asia-Pacific and other regions (see flowchart in Supplemental File 1). The online databases (CINAHL, Cochrane, PILOTS, PsycInfo, WileyOnline, PubMed, Scopus, Web of Science) 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 grey literature search included a range of sources including MHPSS.net, ReliefWeb, ALNAP, ACAPS, Refworld, Freedom House, Human Rights Watch and Amnesty International. The websites used to collect grey literature were identified from previous desk reviews (Greene *et al.*, 2017). In addition, we included relevant reports sourced from UN agencies and NGOs. The literature search was conducted by a research assistant under the supervision of the lead author (see flowchart in Supplemental File 2). For additional information about the methodology, see the UNHCR report (Tay *et al.*, 2018).

Results

The search results yielded 75 documents of broad relevance to the mental health and psychosocial wellbeing of this group (see references in Supplemental File 3).

The epidemiology of mental health and psychosocial problems amongst Rohingya

Our review did not identify any systematic epidemiological studies amongst Rohingya, with the exception of a cross-sectional study conducted amongst 148 Rohingya living in Bangladesh in 2013 (Riley *et al.*, 2017). This study, conducted with Rohingya refugees in Kutupalong and Nayapara camps, recorded high levels of symptoms of posttraumatic stress disorder (PTSD) (36%) and depression (89%). Caution should be used however in interpreting these results because the research instruments had not been validated for the Rohingya population. The relationship between trauma exposure and PTSD symptoms was partially mediated by daily environmental stressors highlighting the importance of daily stress in producing negative mental health outcomes (Riley *et al.*, 2017). This same study found high rates of somatic symptoms, such as medically unexplained headaches and back-pain and health (including mental health)-related functional impairment. About 10% of respondents indicated that they believed they were under a spell, possessed by a spirit or demon and/or controlled by black magic. This study suggests that there is likely to be a high prevalence of a range of mental health conditions including depression and PTSD, as well as somatic

complains, local idioms of distress and associated functional impairment.

There are as yet no published data concerning the prevalence of mental disorders among Rohingya refugees who arrived in Bangladesh since 25 August 2017.

The International Organization for Migration conducted a rapid assessment on mental health and psychosocial needs among 320 purposely selected adults and children in three refugee sites in Bangladesh. Feelings of tension and nervousness were widely reported amongst both adults (over 74%) and children (over 58%). Additionally, refugees reported concerns such as grieving for losses, shortage of food, limited access to education, poor camp and shelter conditions, health problems, restrictions in movement, uncertainty about citizenship status (Grønlund, 2016).

Daily stressors may arise from the context of refugee life but can also be related to the erosion of supportive social structures within refugee communities. Observations reported in qualitative research undertaken in Bangladesh and Malaysia highlight the pervasive sense of mistrust among Rohingya refugees together with fear of exploitation by fellow Rohingya (Prosser, 2006; Kiragu et al., 2011; Hinic, 2016).

There are risks in making direct comparisons of data across studies conducted with different Rohingya groups at different time periods and in diverse settings because the changing context will influence the levels of emotional symptoms and the capacity of refugees to cope with distress. Notably, the wide variations commonly recorded in prevalence of mental disorders (Charlson et al., 2016) may result from contextual influences, methodological issues (particularly when unvalidated standard self-report questionnaires are used), the use of different instruments, as well as the variety in time elapsed since conflict (Steel et al., 2009; Silove et al., 2017).

Concepts and understanding of psychological problems

The literature remains scant about traditional ethno-psychological concepts of mental illness amongst the Rohingya, although it is evident that the body-mind divide characteristics of the dominant medical models in psychiatry and psychology are 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.

Rohingya terms related to emotional distress

In Rohingya, an Eastern Indo-Aryan language, the word waushanti/ashanti/oshanti ('sad', or 'restless/no peace in mind') is used to refer to a variety of reactions including stress, suffering, grief and other forms of emotional pain. The term indicates a lack of shanti (peace)/aramiyath. Extreme distress is often referred to as beshi waushanti/ahshanti and vapivapi thakhan, the latter being used more commonly by new arrivals (A.N.M. Mahmudul Alam, personal communication, 2018). There is no direct correspondence between these Rohingya terms, or local idioms of distress, and the western concepts of 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), 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 recognised terms may correspond broadly 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 (Thawnghmung, 2016). As suicide is strongly condemned in Islam, Rohingya will often conceal these ideas out of shame and fear for being judged.

Field workers in Myanmar reported that if Rohingya women with suicidal ideation disclosed their thoughts to their friends and family, the reaction of others was often judgmental which further increased their agony and shame (Nordby, 2018). In a study among women with young children in the registered Rohingya refugee camps in Bangladesh, 62% reported suicidal ideation (International Organization for Migration, 2018). In a study of a general community sample of Rohingya refugees in Bangladesh, 13% of participants endorsed suicidal thoughts (Parnini, 2013). The lower prevalence of suicidal ideation reported in the latter study may be due to the community sample studied and the different identification methods used to assess suicidal ideation between the studies. Informal follow-up interviews conducted with Rohingya patients referred to counselling services revealed that the patients engaged in active planning in committing suicide such as having a rope at home or an intent to ingest pesticides. These findings support observations from other sources such as key informant interviews conducted with primary health care staff in Kutupalong and Nayapara camps in 2013 (A. Varner and A. Riley, personal communication, 2018).

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 (gayabi aoaj) and delusional ideas (A.N.M. Mahmudul Alam, personal communication, 2018). Rohingya terminology related to severe mental disorders includes words indicating psychosis (foul and matá-horáf) and manic states (demag-chóut/horáf, soudou) and arsu-khasu.

Help-seeking behaviour

Rohingya refugees tend not to seek formal help for mental health problems partly because of a limited familiarity with concepts of mental health and counselling, or knowledge of where to seek services, but also because of stigma and feelings of shame associated with mental illness (R. Islam, personal communication, 2018). Furthermore, mental illness is often regarded as a sign of weakness and only in instances in which a problem is perceived as physical in origin, will medical care be sought (R. Islam, personal

communication, 2018). Because of stigma, individuals with severe mental health problems are often taken care of by family members and are at risk of being ostracised by community members. Amongst 72 Rohingya in Malaysia, 63% expressed hesitancy in seeking professional help when feeling overwhelmed by difficulties, 89% would turn to family and close friends and a minority (15%) would be inclined to seek professional help (C. Welton-Mitchell, personal communication, 2018).

Research conducted amongst Rohingya in Malaysia identified the following barriers to help-seeking (for intimate partner abuse): shame, social stigma, concerns about confidentiality, concerns about legal documentation and language barriers (Welton-Mitchell et al., 2019a, 2019b). In a related study with 245 Rohingya in Malaysia, 80% indicated they would seek help for intimate partner abuse, with a majority preferring to go to family (80%), religious leaders (70%), local organisations (57%) and only 10–12% indicating that they would go to a doctor or mental health specialist (Welton-Mitchell et al., 2019a, 2019b).

Traditional healing methods

Religion is a primary source of strength and support for Rohingya, with many relying on religious practice and a sense of duty to communities and their families (Shakespeare-Finch et al., 2014) to help cope with the oppression they have faced throughout their lives (Duchesne, 2016). Traditional practices, however, are increasingly difficult to observe for Rohingya in Myanmar, due to restricted freedom of movement and lack of available religious services (Amnesty International, 2017). Refugees in Bangladesh and Malaysia have freedom to practice their religion.

In the case of spirit possession (by *jinn/fawri* or ghosts), Rohingya often 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 (R. Islam, personal communication, 2018). Some persons who are considered possessed may suffer from emotional disorders or dissociative disorders, while others may have epilepsy or psychosis. Conversely, some persons experiencing possession states may be wrongly diagnosed as manifesting severe mental illness. Understanding Rohingya traditional help-seeking behaviour and involving traditional healers in interventions is important in the provision of culturally relevant psychological treatment and psychosocial support.

Traditional healing methods play an important role in the treatment of mental health problems in the Rohingya culture. Furthermore, serious mental health problems (such as psychosis, epilepsy, mania) are generally perceived as socially unacceptable behaviour. People with severe mental health conditions are believed to have been cursed by Allah for their own misbehaviour (R. Islam, personal communication, 2018).

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. 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 (*mouloi/habés*, *moulvi/mullah*) and (4) the unlicensed practitioner using western medication (*daac-torr*). Within the refugee settings in Bangladesh, such religious and traditional healers are active and the population seeks their help (Chen, 2018).

Healers are consulted for many different problems, including mental health conditions, seizures, developmental delay and autism (Mollik et al., 2011). 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 lack of enthusiasm, loss of appetite and sleep difficulties. Pregnant women are thought to be particularly vulnerable to the evil eye (Boutry et al., 2015).

Gaps and challenges in providing culturally appropriate mental health and psychosocial support to Rohingya refugees

Since 25th August 2017, the government of Bangladesh, supported by United Nation agencies, and international and national nongovernmental organisations have established a major humanitarian operation for Rohingya refugees and this response explicitly included MHPSS components. However, there are numerous ongoing challenges in relation to care delivery including an overburdened healthcare system with limited human resources and infrastructure. Furthermore, there is a lack of understanding of the Rohingya language, culture and help-seeking behaviour amongst MHPSS personnel in Bangladesh (A.N.M. Mahmudul Alam, personal communication, 2018).

The long history of persecution, violence and discrimination directed at the Rohingya in Myanmar, compounded by prolonged conditions of statelessness and deprivations, increase their vulnerability to psychological distress and mental disorders. High rates of sexual and gender-based violence (SGBV), lack of privacy and safe spaces and limited access to integrated psychosocial and mental health support for Rohingya girls and women, as well as boys and men, remain issues of concern. Even though MHPSS services are increasingly being made available, Rohingya refugees may not always be inclined to utilise these services. One important reason for this underutilisation is the limited familiarity with the nature and purpose of such services. It is important therefore for MHPSS providers to tailor their interventions to the culture, customs, language and religion of Rohingya refugees.

Language

The Rohingya dialect is a spoken language with no universally accepted written script. Although the language shares many similarities with the Chittagonian dialect of Bengali, that is spoken in and around areas surrounding Cox's Bazar, they are not identical (Translators without Borders, 2018). A minority of literate refugees are proficient in English, Rakhine and Burmese dialects. Many humanitarian staff involved in the Rohingya refugee response are however not familiar with the Rohingya 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. The use of informal interpreters however should be limited given issues of privacy and confidentiality and concerns about the reliability of the information conveyed.

Cultural concepts of mental illness

The Rohingya language does not have the equivalent terms for depression, PTSD or anxiety disorder. Therefore, mental health

professionals need to explain clearly when using 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 mental health worker. Providers of MHPSS 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 (Jiwrajka *et al.*, 2017).

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 (Nordby, 2018). For example, matching genders of MHPSS workers and their clients should be prioritised, but this is not always feasible. At a minimum, MHPSS workers should discuss with the woman which conditions allow her to feel 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 relevant beneficiary communities prior to initiating services with the intention of rendering counselling spaces as confidential as possible. Additionally, there are noted gaps in services and referral pathways in camps settings in Bangladesh, for male survivors who also reported different forms of sexual violence (Chynoweth, 2018). Psychosocial service providers should be specifically trained around SGBV for both men and women, as there is a risk of inadvertently reinforcing discriminatory and oppressive structures in formalised services. In Malaysia, a manual to raise awareness around intimate partner abuse has been developed specifically for Rohingya community members (Welton-Mitchell *et al.*, 2019*b*).

Adaptation of materials

MHPSS programmes and activities for Rohingya should draw on past and existing work focusing on the development or adaptation of psychological assessment tools and treatments to ensure they are grounded in local terminology and culturally specific concepts of illness. This can facilitate accurate community case detection and assessment as well as delivery of effective, culturally sensitive and non-stigmatising care for Rohingya. Materials for psychoeducation and manualised treatment protocols for scalable psychological interventions should be adapted to the Rohingya context, piloted before widespread implementation and use appropriate language and examples. For example, the MHPSS team of UNHCR in Bangladesh uses the Rohingya language written in Bengali letters as a mode of communication.

Settings for service delivery

A major challenge is that the settings for MHPSS services in Bangladesh/Myanmar often lack confidentiality. For example, given limited access to electricity and the lack of air flow and tin roofs, providing counselling in a completely confidential space may cause discomfort to both the counsellor and the client. 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 ensure that no harm is done when those facilities are not available (e.g. MHPSS workers should be trained to preserve confidentiality in these settings by lowering their voice to match beneficiaries, etc.).

Acknowledging diversity within Rohingya refugee populations

There is considerable difference between Rohingya groups in their migration histories and experiences such that those in the northern parts of Rakhine State may experience different challenges and issues compared to 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 the summary data presented in this report. The current literature does not allow for disaggregation of differing Rohingya sub-groups according to their specific needs and experiences.

Limitations and recommendations for further research

The operational context in Bangladesh is rapidly changing with many organisations involved in supporting Rohingya refugees. Future studies are needed to examine the nature and course of symptoms amongst the Rohingya to distinguish between normative manifestations of distress and maladaptive/pathological reactions that may interfere with their capacity to adapt over time. Similarly, further research into the effectiveness of services in reducing the nature and course of mental health conditions will provide valuable in guiding best practices for service delivery among Rohingya in the refugee camps in Bangladesh.

Conclusions

The legacy of prolonged exposure to gross human rights violations and on-going systematic discrimination against Rohingya refugees poses enormous challenges to humanitarian agencies tasked with addressing their multiple needs. However, the current crisis also provides new resources and opportunities to develop support and services that are culturally relevant and contextually appropriate. Past exposure to traumatic events and losses need to be addressed in conjunction with ongoing stressors and worries about the future. It is important to design MHPSS interventions in ways that mobilise both 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 conceptualise their suffering and work towards solutions is essential.

References

Amnesty International (2017) *Scorched-earth campaign fuels ethnic cleansing of Rohingya from Rakhine State.* [online] Available at https://bit.ly/2wZWZIE [Accessed 12 September 2019].

Benarnews (2018) *Bangladesh Plans to Begin Moving Rohingya Refugees to Remote Island in June.* [online] Available at https://www.rfa.org/english/news/myanmar/island-04052018171219.html [Accessed 12 September 2018].

Boutry M, Eh Htoo S and Myo Win TM (2015) *Qualitative Exploration on Malnutrition in Maungdaw District.* Myanmar: Action Contre la Faim.

Charlson FJ, Flaxman A, Ferrari AJ, Vos T, Steel Z and Whiteford HA (2016) Post-traumatic stress disorder and major depression in conflict-affected populations: an epidemiological model and predictor analysis. *Global Mental Health* 3, e4.

Chen DH (2018) *In Rohingya camps, traditional healers fill a gap in helping refugees overcome trauma.* [online] Available at https://www.irinnews.org/feature/2018/07/30/rohingya-camps-traditional-healers-fill-gap-helping-refugees-overcome-trauma [Accessed 12 December 2018].

Chynoweth S (2018) *It's Happening to Our Men as Well: Sexual Violence Against Rohingya Men and Boys.* New York: Women's Refugee Commission.

Darusman M (2018) *Statement by Chairperson of the Independent International Fact-Finding Mission on Myanmar,* at the 37th session of the Human Rights Council. Geneva: United Nations Human Rights Council.

Duchesne B (2016) *A Rapid Assessment on Psycho-Social Needs and Resources: Maungdaw and Buthidaung Townships: Executive Summary.* Myanmar: ACF International.

Greene MC, Jordans MJD, Kohrt BA, Ventevogel P, Kirmayer LJ, Hassan G, Chiumento A, Van Ommeren M and Tol WA (2017) Addressing culture and context in humanitarian response: preparing desk reviews to inform mental health and psychosocial support. *Conflict and Health* 11, 21.

Grønlund CA (2016) *Refugees in Exodus: Statelessness and Identity: A Case Study of Rohingya Refugees in Aceh, Indonesia* (Master's thesis). University of Agder, Norway.

Hinic O (2016) *The Challenged Identities of the Stateless Rohingya.* Spain: University of Barcelona.

Holliday I (2014) Addressing Myanmar's citizenship crisis. *Journal of Contemporary Asia* 44, 404–421.

Human Rights Watch (2009) *Perilous Plight: Burma's Rohingya Take to the Seas.* [online] Available at https://www.hrw.org/report/2009/05/26/perilous-plight/burmas-rohingya-take-seas [Accessed 12 September 2018].

International Crisis Group (2017) *Myanmar's Rohingya Crisis Enters a Dangerous New Phase.* [online] Available at https://bit.ly/2BHrxO2 [Accessed 12 September 2018].

International Crisis Group (2018) *Bangladesh-Myanmar: The Danger of Forced Rohingya Repatriation.* [online] Available at https://d2071 andvip0wj.cloudfront.net/b153-bangladesh-myanmar_0.pdf [Accessed 12 September 2018].

International Organization For Migration (2018) *Mental Health and Psychosocial Support Rapid Needs Assessment.* Cox's Bazaar, Bangladesh: IOM.

Jiwrajka M, Mahmoud A and Uppal M (2017) A Rohingya refugee's journey in Australia and the barriers to accessing healthcare. *BMJ Case Reports* **2017**, 219674.

Kiragu E, Li Rosi A and Morris T (2011) *States of denial: A review of UNHCR's response to the protracted situation of stateless Rohingya refugees in Bangladesh.* [online] Available at http://www.refworld.org/docid/5142eb7a2.html [Accessed 4 June 2018].

Lee R (2014) A politician, not an icon: Aung San Suu Kyi's silence on Myanmar's Muslim Rohingya. *Islam and Christian–Muslim Relations* 25, 321–333.

Mollik AH, Akter K, Azam NK, Hossain FB, Rahman H, Chowdhury KBTM, Sen D and Mcfield R (2011) Towards integration of unconventional medicines in the public health service: the experience of Rohingya refugees' In Bangladesh. *Journal of Epidemiology & Community Health* 65, A449–A449.

Nordby L (2018) *Gender-Based Violence in the Refugee Camps in Cox Bazar: A Case Study of Rohingya Women's and Girls' Exposure to Gender-Based Violence.* Sweden: Uppsala University.

Parnini SN (2013) The crisis of the Rohingya as a Muslim minority in Myanmar and bilateral relations with Bangladesh. *Journal of Muslim Minority Affairs* 33, 281–297.

Prosser S (2006) *Made in Bangladesh: Mental Health Assessment.* Tefnak Bangladesh: Medicine San Frontier.

Riley A, Varner A, Ventevogel P, Taimur Hasan MM and Welton-Mitchell C (2017) Daily stressors, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh. *Transcultural Psychiatry* 54, 304–331.

Rogers B (2012) *Burma: A Nation at the Crossroads.* London: Random House.

Shakespeare-Finch J, Schweitzer RD, King J and Brough M (2014) Distress, coping, and posttraumatic growth in refugees from Burma. *Journal of Immigrant & Refugee Studies* 12, 311–330.

Silove D, Ventevogel P and Rees S (2017) The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry* 16, 130–139.

Steel Z, Chey T, Silove D, Marnane C, Bryant RA and Ommeren M (2009) Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *Journal of American Medical Association* 302, 537–549.

Sullivan D (2018) *Unnatural Disaster: Aid Restrictions Endangering Rohingya Ahead of Monsoons in Bangladesh.* Washington: Refugee International (RI).

Tay AK, Islam R, Riley A, Welton-Mitchell C, Duchesne B, Waters V, Silove D and Ventevogel P (2018) *Culture, Context and Mental Health of Rohingya Refugees: A Review for Staff in Mental Health and Psychosocial Support Programmes for Rohingya Refugees.* Geneva: United Nations High Commissioner for Refugees (UNHCR).

Thawnghmung AM (2016) The politics of indigeneity in Myanmar: competing narratives in Rakhine state. *Asian Ethnicity* 17, 527–547.

Thom G (2016) The May 2015 boat crisis: the Rohingya in Aceh. *Cosmopolitan Civil Societies Journal* 8, 43–62.

Translators without Borders (2018) *Rohingya Zuban: A Translators Without Borders Rapid Assessment of Language Barriers in the Cox's Bazar Refugee Response.* Geneva: TWB.

United Nations High Commissioner for Refugees (2010) *Myanmar. Global Report 2010.* Geneva: UNHCR.

United Nations High Commissioner for Refugees (2017) *Mixed Movements in South-East Asia 2016.* Geneva: UNHCR.

US Department of State (2018) *Bangladesh 2017 Human Rights Report.* USA: US Department of State.

Van Waas L (2010) *The Situation of Stateless Persons in the Middle East and North Africa.* Geneva: United Nations High Commissioner for Refugees (UNHCR). [online] Available at http://www.refworld.org/docid/4cea28072.html [Accessed 4 June 2018].

Wade F (2017) *Myanmar's Enemy Within: Buddhist Violence and the Making of A Muslim' other.* USA: Zed Books.

Welton-Mitchell C, James L and Tenaganita (2019a). *Healthy Relationships Curriculum: Incorporating Mental Health, Social Norms and Human Rights Approaches to Empower Communities. Workshop Manual to Raise Awareness About Intimate Partner Abuse.* Kuala Lumpur, Malaysia.

Welton-Mitchell C, James L and Bujang NA (2019b) Understanding intimate partner abuse among Rohingya in Malaysia: assessing stressors, social norms and help-seeking to inform intervention. Kajian Malaysia. *Journal of Malaysian Studies* 6, 11–14.

World Health Organization & United Nations High Commissioner for Refugees (2012) *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for major Humanitarian Settings.* Geneva: World Health Organization.