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Social and cultural factors shaping health and nutrition, wellbeing and protection of the Rohingya within a humanitarian context

Santiago Ripoll[1] and Contributors (See Annex 1)

Summary

Rapid review question:

- *To assess the socio-normative values, beliefs and practices of the Rohingya around health, wellbeing and nutrition, and around the protection of children, adolescents and women (including gender norms) in a humanitarian context.*

- *existence of social classes/ caste or social structure that might become invisible barriers for accessing services (e.g. child-friendly spaces)?*

This review is based on a review of literature and consultation with experts that was undertaken at the end of September 2017. It is important to take this information with caution as much of the literature was produced before the current crisis in which social organisation may have undergone significant change.

Context

- The Rohingya are a stateless predominantly Muslim minority that has traditionally lived in Arakan (aka Rakhine State), in Myanmar.
- Life in Myanmar has been characterised by severe restrictions on movement, livelihoods, political participation, religious life, marriage and procreation, and access to services (e.g. health or education).
- Life in Bangladesh is more secure but still highly restricted (in terms of movement, jobs, access to services), especially for refugees who are not officially registered. The host area is poor, rural and prone to cyclones.
- Rohingya Islam is part of the Sunni branch of Islam. Within that it belongs to the Hanafi school of religious thought which is relatively more traditional than other branches of Islam. Culture, however, is changing and there are generational differences.
- In Arakan state, in Muslim Rohingya villages, prominent authorities included: *mullahs* (Quran scholars who often led mosques), *mulvis* (heads of the madrassas) and elders. Public administration committees in each village comprise people from these groups. The village chairman's role is to negotiate between the Myanmar government, border police and resident Rohingya populations. It is not clear what has happened to these people in the latest wave of violence or whether their dual facing role could have undermined trust in them among lay Rohingya. Other prominent figures of the past were the *Shodor (or sódor)*, traders and members of village societies (*sómaj*): men in charge

[1] Santiago Ripoll, Network and Research Officer, Institute of Development Studies, University of Sussex. Email: s.ripoll@ids.ac.uk

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of redistributing charity and *zakat* (compulsory donations to the poor), and the *háfes* (people who had learnt the Quran by heart and preached it), which can on limited occasions include women. These positions have lost significance in recent times due to Myanmar government pressure, but people who used to hold them may command trust.

- The upholding of *purdah* (preventing women from being seen by men other than their husbands) is a symbol of individual pride and the family's status. It is a major determinant of the extent to which women are able to engage in work or public life outside the home. The dire economic situation in camps means more women have become breadwinners and are taking part in non-traditional work. This appears to be causing increased social friction rather than women's empowerment and women have been the victims of gender violence and harassment.
- Marriage is very important for the Rohingya and for women it is often the only way they will achieve a sense of security given they are discouraged from working. Child marriage and polygamy is infrequent but it has been increasing in recent years due to the scarcity of men and to economic difficulties which mean girls are forced into adult roles sooner.
- Upon marriage a woman becomes the responsibility of the husband's family; in addition to her husband, she becomes the responsibility of her mother-in-law who gives guidance on behaviour, childcare and other gendered tasks.
- There are no social castes within the Muslim Rohingya. Social difference may arise to income disparities, urban or rural residency, status in terms of (normally religious) education and community secular and religious responsibilities, as well as gender and age differences.

Key points and recommendations

1. Finding trusted and respected stakeholders for C4D

- There are a number of traditional and religious leaders who could be engaged to achieve humanitarian goals, including:
    - *Mullahs, Imams and Mulvis*, working through the local mosque and madrassa
    - *Shodor and members of village societies (sómaj):* the enacters of Zakat and other forms of charity, for messages about childcare and protection geared toward males in the community.
    - *Traditional and spiritual healers*: for understanding and messaging around healthy behaviours, as well as identification of illnesses and referral to clinics.
    - *Women háfes (when available) and midwives* - for women, especially messages around sexual and reproductive health.
- However, a quick assessment to see who people trust beyond these traditional roles could be invaluable (e.g. returned migrants, business/trades people etc).
- Messaging should be in Rohingya language whenever possible. Literacy levels are low but there is potential use of traditional poems and music, e.g. *Tarana* songs as a vehicle for messages.
- Mothers-in-law hold considerable influence in household decisions, especially around childcare and maternal health. Whether they are resented or trusted may depend on the family, but they are an important stakeholder group.

2. Working within the idiom of Rohingya islam

- Religion is crucial for wellbeing and is a major social organising principle: meeting religious needs may be as important as meeting material needs and should be considered in the design of programmes and structures, e.g. mosques to ensure they have the minimum structural features to meet Islamic precepts (orientation, pulpit and

niche); the segregation of latrines, or provision of women or girl only activities, and chaperoning, to uphold *purdah*.
- Purdah is inevitably intertwined with security concerns about gender violence, therefore it is important to guarantee appropriate policing, accountability of those guaranteeing security, appropriate lighting and provision of services in areas that are not too remote.

3. Health: Working with different kinds of care-providers and decision makers

- Rohingya populations are used to experiencing major barriers to accessing formal healthcare. The experience of discrimination, lack of respect for local traditions, and racism when accessing services is also likely and humanitarian interventions will have to ensure they do not recreate such environments.
- As fear and anxiety is likely to prevail communication and interpersonal skills will be important, as will translation. Female staff should be available for female patients.
- In place of formal health services, people also use homemade remedies and consult other health providers. These include traditional healers, herbalists, shopkeepers (who give medicines and impart medical advice), and faith healers. Therapies include western medicines, herbal remedies, and those connected with *jinn* (spirits) and prayers.
- Rohingya understandings of disease and health are intertwined with spirituality and religion and other spheres of life, such as economic problems. Economic difficulties, malnutrition, mental health issues, can be attributed either to *jinn* (spirits) or evil eye.
- The husband and the mother-in-law are often the ones who decide where to seek treatment.
- Communication initiatives should engage with pharmacists and traditional and Islamic healers for disease prevention and control, getting messages through them, as well as incorporating them into referral systems.

4. Water and Sanitation

- There are opportunities for synergies between religious and health concerns: water points should be available for ritual washing (*wudu*) in mosques, where men pray, and near homes, for women who pray at home.
- To uphold Purdah, it is preferred if latrines are gender segregated. Since women are at risk of gender violence, appropriate lighting and security in the camps is paramount.
- Latrines should be built on a north-south axis, because it is not allowed to defecate facing west (towards Mecca). The community should be consulted when placing latrines.

5. Reproductive health

- *Háfe* women and midwives when available, are good interlocutors to reach women to discuss sexual and reproductive health, as well as other humanitarian issues around nutrition, wellbeing and watsan. Mother in laws are also influential and fostering discussion with them as well as mothers will be necessary. Cultural sensitivity by humanitarians and policy makers is paramount.
- Contraception can be justified in Islamic terms, in terms of the responsibility of the family to provide for every child born and not to bring children who cannot be cared for into the world.
- Strict population control measures in Myanmar since 2015 have forced women into unsafe abortions. Planners should anticipate an increase in marriages (which previously required a permit) and pregnancies, as well as provide obstetric care for sequels of unsafe abortions. Similarly, a large number of unregistered children will need to be documented.

6. Nutrition

- Nutrition outcomes are determined by household income, education and size. These factors are more important than social and cultural factors. Other important factors are dietary diversity (also linked to incomes), immunization levels and childhood illnesses.
- Recorded rates of malnutrition in Myanmar did not differ between boys and girls. The presence of girls was higher in feeding programmes, possibly because boys are considered to be stronger. There is a sense of shame of having a malnourished child (*ganda* child) because it signals that the family has not been able to care for him or her.
- Ensure diets are diverse and culturally appropriate by discussing the contents of food baskets with refugees (e.g. what pulses to include, what ingredients, etc.).

7. Mental health

- Poor parental mental health and acute environmental stresses can impact negatively on child care and early child development. Mothers should be supported to cope with mental health problems such as PTSD or depression. Efforts should be made to understand the way trauma and mental health conditions are experienced, recognised and dealt with by the Rohingya as it may differ from Western definitions and diagnoses.
- Mental health issues are sometimes spoken about as a result of *jinn* possession. Acknowledging this will help in terms of diagnosis, how the solutions are explored, and whether stigma is experienced. Biomedical and spiritual ideas about causation are not mutually exclusive and therapy could be framed in the same idiom of *jinn*.

8. Protection: safe spaces and participation of women and children

- Access to 'child friendly' spaces and services is limited by children's socio-economic obligations and *purdah*. Young boys (12- 18) may be kept from youth activities due to casual work or seasonal labour. Girls' access is restricted when they reach puberty due to *purdah*, through which they need to stay home to help their families. Time consuming household chores may limit opportunities for girls to participate in activities. Flexible timings may partially address this. Security and purdah concerns can be relieved by allowing siblings or mothers to accompany younger siblings to activities or spaces. Another factor may be parents thinking of their stay in camps as 'temporary'.
- Marriage is traditionally perceived to be the safest way to secure a girl's livelihood. The median age for women's marriage in Rakhine State in 2016 was 20.7 years. The difficult circumstances in the camps may mean that parents push their daughters to get married earlier than they would have otherwise, because they cannot afford to provide for them. Polygamy and child marriage is not only an element of culture but it is an adaptation to the lack of livelihood opportunities in the camps.
- Sexual and gender violence is commonplace both in Arakan state and in camps and is often perpetrated by officials and elites. The position of power of those representatives makes redress and prevention a challenge.
- Domestic violence is mostly understood as physical violence, and women do not necessarily perceive psychological abuse as violence. When domestic violence is perpetrated, it is often by husbands and not by other members of the family-in-law. Domestic violence is perceived as a "family affair", to be solved by the family alone.
- Serious challenges exist around the drivers, recognition and reporting of sexual, physical and emotional abuse, and abuse against children. As well as engaging households on risks and sources of support, efforts should be made to ensure reporting and redress systems are accountable and potential perpetrators (e.g. officials and elites) do not end up with discretionary power. Vulnerable groups should be consulted in the design of such systems.

Introduction

More than half a million Rohingya refugees, 60% of them children (UNICEF 2017), have crossed the border into Bangladesh, joining refugee camps or settling informally, and are in dire need of basic services such as food, health care, and protection. To support their humanitarian intervention, UNICEF have requested a rapid evidence review:

- *To assess the socio-normative values, beliefs and practices of the Rohingya around health, wellbeing and nutrition, and around the protection of children, adolescents and women (including gender norms)* in a humanitarian context

And, as a subset of this question:

- *To assess the existence of social classes/ caste or social structures that might become invisible barriers for accessing services (e.g. child-friendly spaces)?*

To answer these questions, this paper first explores the broader context of Rohingya in Myanmar and Bangladesh; then it explores key religious and cultural practices that are relevant to issues of health and protection; the following section explores aspects of health in more detail such as sanitation, nutrition, maternal and mental health. Finally the report closes with a set of preliminary recommendations.

Methods and scope

This paper draws upon an extensive desk review of more than 50 peer-reviewed articles, research papers and humanitarian reports[2]. It also synthesises the contributions of 11 regional experts who were interviewed or sent email responses (see Annex 1). Contributions from these experts are indicated in the text as 'Contribution [surname]' to differentiate them from written sources. Consultation with experts allows for the inclusion of up-to-date insights and a broader range of perspectives that are not available in published literature.

This review does not cover all humanitarian issues affecting the Rohingya. It focuses on aspects of socio-cultural practices which seem to play a significant role in health and protection. It is important to take this information with caution, and it cannot replace a social analysis to be carried out in settlements or camps. The information we have gathered in this rapid review is not a blueprint for action, but rather a discussion of the social and cultural factors of the Rohingya that *may* play a role when discussing humanitarian priorities. The information should come from the Rohingya themselves and through consultations on the ground (contribution Aron).

This report contains information about society and culture which came from settlements in Myanmar that existed before the latest attacks and displacement, from villages many of which are now burnt down and depopulated (OCHA 2017). It would be expected that the experience of forced migration and readjustment to a refugee camp will have changed social organisation. Other sources of evidence look into camp life, but even these need to be taken with caution, since there are different 'generations' of Rohingya' refugees: camps have been set up in Bangladesh since 1991 (when 250,000 Rohingya crossed the border) and in recent military attacks where the outflux of Rohingya refugees has reached half a million. This means that in camps like Cox's Bazar, there will be long established refugee populations coexisting with a massive new demographic of newcomers.

[2] The review includes 18 peer reviewed articles, 3 academic books, 6 academic non-peer reviewed articles, 2 academic thesis, 10 UN reports, 8 NGO reports, 6 websites on Rohingya culture and news, and 6 news items.

The context

The Rohingya, who have traditionally resided in Myanmar's Rakhine State, are not recognised as a legitimate, native minority by the government. Since the 1982 Citizenship Law, in which the Rohingya were not included in the list of the country's minorities[3] and were stripped of nationality (being considered Bangladeshi aliens) and became stateless.[4] Before that, the Myanmar state had created a strict regime that discriminated against Rohingya in terms of freedom of movement, access to education, access to health and livelihoods since the military coup of 1962 (Mahmood et al 2017). All this was enforced by the NaSaKa, the border police force[5]. State repression is compounded by intercommunal tensions between the Rohingya and the Buddhist Rakhines (Farzana 2011: 222).

During and after the 1990 election, "persecution in the form of physical and mental torture such as beatings as well as killings, abduction and rape, economic exclusion, and restrictions on physical movement threatened their livelihood security and physical security to the extent that it forcefully displaced thousands" (Farzana 2011). Traditionally a rural people engaged mainly in agriculture and fishing, the Rohingya who remained in Myanmar were initially forcibly displaced from their hometowns to 'model villages' (Lewis and Lone 2017). These model villages were perceived to be more like prisons or IDP camps. Repatriation to original homes and lands was not allowed (Advisory commission for Rakhine State 2007).

Life in Myanmar has meant a lack of access to services (e.g. health or education), movement, jobs and participation, for example Rohingya were not allowed to vote in the 2012 elections and have lost all political representation. On occasions men were forced to work. Travel permits to leave the village had prohibitive fees (Mahmood et al 2017). Religious freedom was also curtailed, with the destruction of mosques and appropriation of *Waqf* (mosque) land (Palmer 2011: 105). The Myanmar state (and a majority of Myanmarese) perceive the Rohingya as a 'population problem' and has initiated a two child policy (only for the Rohingya) and a minimum time lapse between pregnancies (36 months between births) since 2015 (Blomquist 2016), as well as a system of expensive and hard to get permits to get married and register children (Mahmood et al 2007).

Before the latest mass displacement, the largest concentration of Rohingya was in the north of Rakhine State (also known as Arakan), especially around Maungdaw, Buthidaung, Rathedaung, Akyab and Kyauktaw. In 2012 and most recently in 2017, allegedly in response

[3] Please note that Muslim Rohingyas are not the only Muslim minority in Burma, although it is the only one that it is unrecognised officially as a minority. In this report we will only cover the Muslim Rohingya.

[4] The history of the Rohingya in the Rakhine region is contested. Rohingyas describe themselves as the descendants of Arab traders who settled in Arakan country in the Bay of Bengal as part of the expansion of Islam in the 8th and 9th century. These traders predicated Islam and intermarried with locals. The Rohingyas see these Muslim communities as their forefathers. It is recognised by both Rohingyas and the Rakhine Buddhist that during British rule of Burma (1824-1948) there was a population intake from the Chittagong area of Bangladesh into the Rakhine region. Myanmar State discourse claims that today's Rohingyas descend *only* from that (19th-20th century) immigrant population or even more recent immigration, whereas the majority of historical research is that the Rohyingas are a combination of several populations, some longstanding and some more recent (Ardeth Maung Thwanghmung 2016).

[5] The NaSaKa police force is officially a border police force, yet its key role has been to implement discriminative policies against the rohingya such as movement restriction, two child policy, and marriage restrictions. It was disbanded in 2013, yet the policies continued to be enforced by the national police (International Crisis Group 2013).

to inter-community attacks and attacks from the Arakan Rohingya Salvation Army (ARSA)[6], the Myanmar state has launched military operations against the Rohingya which have unleashed waves of violence that has included "villages have been burned down, parents or relatives have been killed in front of traumatized children, and women and girls have been raped or brutalized." (OCHA 2017). The violence has created a mass movement of Rohingya, and now 50% of all Rohingya villages stand empty, "half the population has been displaced in the space of three weeks and unknown thousands (…) have been killed." (Brinhan 2017). Some Rohingya land has been confiscated and allocated to Buddhist Rakhines (Masood contribution, Gronlund 2016: 48-9), and the displacement of Rohingya from Arakan opens the door to gas and oil exploitation by the Myanmar state[7] (Gronlund 2016).

Seeking refuge

Most of the Rohingya refugees have sought refuge in Bangladesh, although others have done so elsewhere in countries such as India, Indonesia or Malaysia. The need to find refuge puts them at risk of trafficking (ECHO 2017). Transit between countries puts them at risk of kidnapping (by criminal groups or corrupt immigration officers) and use as forced labour (Akm Ahsan Ullah 2011).

Whilst relatively more secure, life in Bangladesh is still challenging. Over six to eight hundred thousand Rohingya now live in Bangladesh, and only a little over 30,000 have a UNHCR refugee card and are officially registered as refugees. Without a card "unofficial Myanmar migrants" are not allowed to work or pursue education. Movement is severely curtailed for all refugees, making access to services such as health challenging (ECHO 2017). The refugee crisis is protracted, so for example in Nayapara camp in Bangladesh, 58 percent of the camp population was born there, and most of the refugees have been there for over 20 years (Asma Masood). In long-term host countries, the distinction of being documented or not also makes a difference to people's sense of security, and to the job opportunities they can pursue.

Some refugee camps are situated near a restricted area with a Chakma indigenous minority, indeed some of the doctors in camps are Chakma. Chakma are marginalized in Bangladesh which makes it difficult for them to speak out about some of the issues in the camps. Navigating these ethnic tensions will require more attention (Contribution Oosterhoff).

Livelihoods

The Rohingya have traditionally pursued agriculture or fisheries as their main livelihoods. Urban Rohingya used to be involved in business and trading, or as manual labour. Before the conflict with the State of Myanmar unfolded, better off households owned land or were engaged in fishing, whilst those on lower incomes survived through manual labour in fishing, agriculture and petty trade (SCI 2014). This was before the restrictions that were imposed by the state since the 1960s. In recent times, Rohingya in Arakan have depended mainly on casual labour, mostly in agriculture.

The movement restrictions have meant: "little access to sea land or other productive assets. Main markets and business centres remain accessible, limiting opportunities for work" (ibid).

[6] The ARSA claims they formed as a group of Rohingya youths responding to the 2012 military attacks. Their first attack happened in 2016. They claim to be circumscribed to areas inhabited by the Rohingya and to be there to protect the Rohingya from attacks. The Myanmar state, however, draws links between ARSA and linked to international Islamist terrorist groups.

[7] China has opened a pipeline in Arakan, and they also are the main purchasers of Myanmarese market, which makes it the country with most leverage to pressure Myanmar for change (Masood 2015). Whether they are interested in this mediating role or not, is another question.

The lack of movement means that people cannot find secure jobs, and they are also denied local and national level positions (Kazi Farmida 2017).

In the refugee camps in Bangladesh, because of movement restrictions and the impossibility of seeking employment through legal means, Rohingya refugees get involved in rag picking, recycling, foraging and providing day labour informally. Depending on where the camp is located, other casual jobs may arise, like working in a soap factory, or in the shrimp business, housebuilding and so on (Uddin and Khan 2017).

There are disparities in the incomes of Rohingya when they arrive: "A small percentage that arrived with assets and contacts (…). By far, most will remain dependent on camp resources in every way." (contribution Mirante).

Work in refugee camps in Bangladesh is mainly carried out by men and women stay at home doing housework (contribution Masood), although the economic realities of the camps are changing this. A large number of men have either been killed or detained, and many men are also migrating to a third country (from where some of them send remittances back[8]) or embarking in fishing boats (MSF Amsterdam, 2007). This means that there is a large number of female headed households in the camps (19 percent of Cox Bazar's households, according to IOM 2017), and that the economic necessity means that women are starting to become breadwinners in the household (de Chickera). As discussed below, this has created some tensions within the households and a rethinking of the role of women within Islam and the relevance of *purdah*.

Language

Rohingya language is an Indo-Aryan language, of the great Indo-European family. It has a large number of Urdu, Persian, Hindi, Arabic, Burmese and English loanwords. It has been written in different scripts, including in the roman script. Rohingya is related to the Chittagonian language, which is spoken in the South-eastern Division of Bangladesh. Speakers of Chittagonian and Rohingya can understand each other to a degree. Messaging in Chittagonian can be partially understood by Rohingya refugees, but for complete comprehension messaging should occur in Rohingya. Chittagonian and Rohingya are related to Bengali but not intelligible by them (Azizul Hoque 2015: 58).

Status and social organisation

This section explores forms of social and religious status in Rohingya villages as it was in the past, before the current crisis. Much of this information is based on a report by Action Contre la Faim (2015). It is important to note that mass displacement and resettlement in camps may have changed the people's status and therefore their potential command of people's trust. These prominent people may still retain their prominence and prestige amongst the community, and it is important to engage or consult with them (Sardina Galache contribution).

Within Myanmar civil governance, villages tracts (that could include several villages) were administered by a Rakhine Buddhist[9] and under their authority in each village there would be a village chairman (*Chay Ywa Okkata* in Burmese), a local Rohingya leader, who had prominence due to wealth and land ownership. These Rohingya leaders would usually also

[8] Elzbieta Godzdiak reports that long-term Rohingya migrants in Malaysia are likely to find a new local partner or wife, hence undermining the support and remittances that they might have sent to their first wives in Arakan or Bangladesh.

[9] Village tract (often a group of 2-5 villages) boundaries would be set out so as to ensure that a group of Rohingya villages would be incorporated with a Rakhine Buddhist village, and the admistration of that village tract would be appointed to a Rakhine Buddhist.

have belonged to mosque and madrassa committees (created by the border police NaSaKa).

*Mullah*s, the heads of the mosque, and the *Mulvis*, the heads of the madrassas (Quranic school education) were also influential, and often commanded higher incomes when leading wealthier communities. Their position within Rohingya society (as member of the committees above) was very ambivalent as they had to negotiate the demands of the State authorities and those of their own people (ACF 2015:7).

In refugee camps, *mullahs* and imams leading prayer in mosques have been reported to be very influential. As will be shown below, and as mentioned by UNICEF staff, the existence of a mosque for prayer is a key preference and upon arrival refugee imams set up mosques, and on the back of those mosques, water points. Respect for these religious figures and their potential role as interlocutors with the community should be taken into account for messaging.

Háfes are people who have memorised the whole Quran. Although mostly men, there are also women *háfes*, and they often come from a lineage of *háfes*. They command a lot of respect from the community. In the past, some women (some of them *háfes*) also carried out pilgrim tours (*Musk'rat Jamaat*), teaching Islam to surrounding communities (ibid: 8). *Musk'rat Jamaat* does not only involve the teaching of Islam, it also includes "gender oriented teachings on sexuality, marital life and values that should be respected by Muslim women" (ibid: 9).

In Rohingya communities, there are secular organisations of elders and bachelors called *sómaj.* The members of these committees were called *shodor.* The role of the *sómaj* is to enact the community members' obligation to each other, it reinforces the 'social bonds' of the community[10]. Originally, before the 1990s, this secular administration was responsible of keeping order in matters outside Islamic law, for example mediating in neighbour and familial conflicts, as well as collecting *zakat* (an Islamic form of charity/social redistribution) (see below): "All social welfare activities like Adhahi meat distribution, helping the poor, widows, orphans and needy, marriage and funeral functions are done collectively by the *sómaj*" (Islam 2006). They also appealed to community to help people who were destitute. Since the 1990s they have become less relevant, but they still command respect from the community.

Wakar Uddin, the Director General of the Arakan Rohingya Union, cautions us in his contribution to see these social positions (the shodor, *sómaj*, and the *háfes*) as the social organisation of the Rohingya in a distant past, rather than recent. The constant attack on local institutions by the Myanmar government, which they perceive as illegitimate and subversive in the past decades has "undermined the social fabric" of Rohingya society. Even in the case of *mullahs* and *mulvis*, he highlights how the persecution of religious people, the destruction of mosques, higher religious education institutions, and historical documents have undermined the status of these figures. It is worthwhile, however, to enquire if any refugees that held those positions in the past are available and if they can command trust amongst the Rohingya.

[10] The notion of community under Islam, of *ulema* is essential in Islam, and the *sómaj* carried that 'social bond' into practice

Islamic practices and social customs of the Rohingya

This section explores the Islamic practices that are most relevant to health, nutrition, wellbeing, and protection. It does not aim to summarize all the beliefs, practices and values that make up Rohingya Islam[11].

Rohingya Islam is part of the Sunni branch of Islam. Within that it belongs to the Hanafi school of religious thought[12]. Whilst not as conservative as the Hanbali school (e.g. Saudi Wahhabism), it is relatively more traditional than other branches of Islam. For example, Rohingya refugees in Malaysia counterpoise their moral high ground with regards to the Malaysian Islam which they see as too lenient (in terms of the number of prayers and the food restrictions: e.g. Rohingya don't eat crustaceans and Malaysians do) (Azis 2014). In answer to the second question of the review, the fact that the Rohingya are Muslim, it means that there is no caste system in place. Social difference may arise to income disparities, urban or rural residency, status in terms of (normally religious) education and community secular and religious responsibilities, as well as gender and age differences.

Religion is crucial for wellbeing: "key facilities for practising Islam, such as graveyards, madrassas (religious schools), and mosques – [are] related to individual and community spiritual wellbeing" (Palmer, page 103). Meeting religious needs are as important as meeting material needs. Religious education in madrassas has been crucial, particularly since there have been periods in Rakhine state in which young Rohingya did not have access to formal education and would receive much of their training in madrassas.

The physical existence and attendance to mosques is important. Even when migrants move to places where they don't speak the language (India or Malaysia), they find solace attending worship in mosques. In villages, men gather in the mosque for the 5 daily prayers, whereas women pray at home. The mosque gatherings on Friday allow for settling conflicts and socialising (ACF 2015: 18).

Prudent behaviour in mosques (including makeshift or adapted ones like a community centre) is paramount (e.g. taking off shoes) for good community relations, as is building mosques appropriately. For example the entrance door needs to be built on the east side, there has to be a *minbar* (the pulpit from which the Imam addresses the congregation); and there should be *mihrab* (the niche placed in the wall of every mosque to indicate the direction of Mecca). The size has to be big enough for Friday prayers (*Jum'ah*) to allow the whole community to pray together. These demands were voiced in a study conducted in Leda camp. In the same study, availability of prayer mats and a carpeted floor was deemed important by respondents (Palmer 2011: 103).

Ablutions (*wudu*, the obligatory ritual washing) before prayer require water facilities near the building designated as a mosque. The importance of *wudu* and water availability is even more important for women who pray at home. When designing water points, the needs of women for ritual washing have to be taken into account as well.

Men grow beards and women are expected to wear hijab or headscarf (see below). In Myanmar, men were persecuted for growing beards and engaging in religious gatherings and communal prayers.

[11] Since we are focusing on the Muslim Rohingya, and in answer to the question, there are no castes in Islam. Please note that there are a number of Rohingya Hindus were displaced in the most recent attack (contribution Farzana), this social group will not be explored in this paper.
[12] For a brief chapter summarising the beliefs, practices and values of Islam, please read Koenig and Shohaib (2014)

Purdah

Purdah, which literally means “curtain”, is the practice of preventing women to be seen by men other than their husbands. As part of purdah, Rohingya women are expected to remain inside the home and take up traditional gender roles, such as housework and childcare. When women do leave the home, they have to be covered by a hijab or headscarf. The upholding of purdah is a symbol of the family’s status: “Women's proper behaviour as sheltered persons becomes an important source of the status of their protectors and their behaviour becomes important in terms of honour and family pride for the entire kin group (ACF 2015).[13]” In this context, being covered by a hijab or a burka actually enhances women’s movement and freedom, because otherwise they would need to stay home. The need for this “symbolic shelter is based on particular understanding of the human condition where “strong impulses such as sexual desire and aggression prevail”. They are also based on a strong and very fragile male pride. For women, maintaining purdah is a sign of religious achievement (ACF 2015: 12)

In Arakan, there was a socio-economic aspect of purdah. Richer families were the most able to maintain purdah, with the woman staying at home, and would be respected and prestigious in the village. Poorer families would need for women to go off to work which can be seen as a transgression of purdah. In a family whose fortunes were improving, women would be brought indoors. This links to the requirement for men to be the breadwinners (Suryanarayan 2016), and the anxiety that it creates for them when women have to contribute to the household by working outside. Similarly, women who have to work can feel guilty that they are not meeting their religious demands, whilst at the same time feeling like they are not dedicating enough time to their children and to the household. In families where women do paid work, they are still responsible for the household chores and raising children.

The circumstances in camps are challenging these gender roles. The dire economic situation means more women have become the breadwinners. Women engage doing house cleaning, washing or childcare for others. The increase in paid work has not come hand in hand with greater empowerment. Rather the opposite, women have been victims of gender violence and harassment both in the home and in the camps. This is compounded by the experience of violence by men at the hands of the Myanmarese, which increases the risk they engage in Gender based violence against women (Akhter and Kusakabe 2012).

Concerns about women’s seclusion are also driven by an increasing sense of insecurity outside the domestic space, be it in camps or villages. Frequent instances of gender violence in camps and communities substantiates these perceptions (ACF 2015, 13).

Zakat and social solidarity

Zakat is a form of mutual aid characteristic of Islam (as we saw above, managed by the shodor in the communities living in Arakan). Those who have the economic means will be obliged to pay zakat, which can be up to 2.5% of their income and which should be redistributed amongst the poor. The number of people eligible to give zakat and the quantities circulated constantly decreased during the duration of the conflict, due to the difficult economic circumstances the Rohingya were facing (ACF 2015).

[13] As shall be shown below, when a women marries a man, she now belongs to the realm of the man’s family, so her observance of purdah directly impacts on the honour of the mother-in-law and her in-laws. Observing purdah is necessary for the woman to minimise conflict with the mother-in-law and the husband.

Other forms of mutual aid are everyday charity for the poor and vulnerable (such as the elderly), donations at the end of Ramadan (Sadaqah al Fitr) and donations for Eid al Adha (between one or two months after the end of Ramadan.)

Zakat and other forms of mutual aid are important because they encourage a religious understanding of redistribution and a community responsibility towards the most vulnerable and destitute.

Marriage

Marriage is traditionally arranged by the parents and is considered a religious affair. In Arakan state, conflicts related to inheritance, marriage and separation are dealt by the *Mulvis*.

Marriage is very important for the Rohingya, particularly for women. Since upholding purdah (see above) and the custom of the man being the breadwinner, requires women not to work, marriage is the only form of security: "their only means of safety, both economically and physically, is through marriage." (ACF 2015: 17). Arriving in the camps, women see it as a "relief with finally being able to marry and start families, and that it is good to have family and children to spend time with in the daily life they have now as refugees waiting to continue their lives." (Gronlund 2016). Further, in the camps, women are getting married at a younger age due to the lack of economic opportunities. Marriage for one's daughter is pursued as a custom, but also as an adaptation for the lack of funds to pay for schooling (SCI 2015: 24).

Even though Islamic law does not allow for dowry, it is common for the family of the bride to pay dowry to the husband's family. The marriage is preceded by a prenuptial agreement, and the dowry is described as a "gift" *(hadiat)*. The size and value of the dowry depends on the wealth of the households. Dowry is also practiced in the camps in Bangladesh, even though it is still illegal there, and there are reports of women migrating to be able to afford dowry and hence to get married (Holmes 2015). Dowry also represents a degree of security for the woman, since in the case of unilateral divorce by the husband, he would need to repay the dowry in full (Nazrul Islam 2012). Because men are becoming increasingly 'scarce' dowry prices are increasing. Dowry is a very frequent source of intra-household disputes, between husbands and wives and between wives and their mother in laws.

The Rohingya culture is patri-local, which means that when a couple gets married, the woman moves into the mans' family home and becomes the responsibility of that family[14]. In particular, she becomes the responsibility of the mother-in-law, who (together with the husband) is supposed to give the woman guidance in terms of her behaviour, childcare and other gender allocated tasks: "When becoming daughter in law, the woman will be transmitted her in-law family's values, including how they should behave in regards of Islam (…). Therefore, after marriage the woman's new family is her step-family. Hence the elders (husband and spouse) with their married son(s) and daughter(s) -in-law compose the ideal household. Decision makers are the elders and the elder son (if not, the elder daughter)." (ACF 2015: 18)

Polygamy is seldom practiced: the rate of polygamous marriage in Rakhine state (which would also include the Buddhist population as well as the Rohingya) is 7 percent (MoHS and ICF 2017). According to Islam, you can have several wives (up to four) if you don't

[14] Both spouses keep their original names, however.

discriminate against them. Poligamy occurs more often in higher income households in rural villages (ACF 2015). The lack of men (due to death and migration) means that in refugee settings polygamy is practiced more often (ACF 2015; WFP and UNHCR 2012).

Since the 1990s, the Myanmar government has prohibited polygamy and required that Rohingya obtain a permit from the NaSaKa in order to get married. The law prohibits cohabitation or sexual contact before wedlock and can lead to 10 years imprisonment (Lewa 2009). Yet marriage permits are costly, often involve bribery, and can take years to be granted. These measures have been introduced as part of the government's population control legislation against the Rohingya which also includes the two child policy. In practice this has meant that many couples have not registered their marriage, and unsafe abortions are practiced and a large number of unregistered children have been born. Thus upon arrival to Bangladeshi camps and away from these restrictions it expected to see a dramatic number of marriages and births (contribution Masood).

Marital separation in Arakan is overseen by the *Mulvi*. The divorcees must live separately for three months and cannot engage in other relationships in the meantime. The children are the man's 'property', hence they would remain part of his household (unless they are being breastfed) and taken care of by the mother-in-law or other female members of the in-law family. If the divorce is due to adultery by the man, the woman can claim the children for herself.

Gender Roles

Gender segregation is common amongst the Rohingya. Girls are expected to stay in the home and be close to their family, whereas boys are more present in the public sphere. When girls reach puberty, they are more likely to be separated from boys, and parents will not send their young girls to educational or recreational activities unless they are segregated (SCI 2014: 16). This is exacerbated by security concerns where girls are kept home to protect them from attack, in both Arakan communities and in refugee camps (ibid). It is important to note that the intensity of gender segregation and upholding of purdah varies according to levels of education and wealth, urban vs. rural, and whether they are in Arakan state or as migrants oversees.

There is no gender segregation until a girl reaches puberty. Both boys and girls have household chores, but girls are oriented towards the home e.g. washing, cleaning and feeding backyard animals, whilst boys perform tasks such as fetching water. Boys are more likely to play outside. According to Save the Children, when girls reach puberty they are taken out of the public space which "belongs to men, boys, children and to some extent married women". (Save the Children 2014: 24).

Women's social life revolves within the domestic realm: a woman mainly interacts with women in her own household, her family members if they visit, and her closest neighbours. Women rely on the women in her household for her knowledge of Islam and of women's health and reproductive issues. As mentioned above *háfes* women can also provide counselling in the pilgrim tours (Musk'rat Jamaat) on "personal matters, such on how to behave with one's husband, how to behave when pregnant, how to deal with the first menstruations, etc.". This places women *háfes* as good intermediaries for women's reproductive health messaging. (ACF 2015:18)

Music

This short section explores different mediums through which culture is transmitted and which can give ideas on how to transmit values and messages.

Music plays an important role in Rohingya culture and has played a role also in resisting the impact of the Buddhist culture. “Muslims who came to Arakan brought with them Arab, Indian, and especially Bengalese music and musical instruments. Persian songs are sung by Arakanese Muslims to this day.” (Siddiqui 2012). *Tarana* poems/songs are a form of oral tradition to keep Rohingya history alive, as well as a way of transmitting “feeling, sentiment, and emotion through songs is thus an excellent means of preserving identity and displaying passive resistance” (Farzana 2001: 223). *Tarana* is sung individually but can also be sung in groups. Farzana reports of Rohingya refugees in Nayapara camp camping out between the huts every month or two with the permission of the Camp-in-Charge:

> “At these gatherings, they use their traditional instruments (*juri* and *tobla*) and sing country songs, religious or philosophical songs, and songs that represent their everyday issues in the camp. Although the group performances in camp are mostly by men, women are welcome as well. As these gatherings take place within the spaces between huts, the women can also enjoy it from inside their rooms. Such occasions not only provide them with entertainment: the impact is greater as they pronounce their frustrations together, recall their memories, transmit them to the new generation, and bond themselves together.” (Farzana 2011: 224)

“Home” is remembered, celebrated and preserved through these songs in the camps. Songs will recall what an Arakan “home” is, for example the rural peaceful place, a “well-ordered lifestyle”, and “houses surrounded by trees, with a garden and tube well”, with “memories of dried food on the rooftop, and in the backyard or in the field, those fresh green chilli gardens” (Farzana 2011: 225)

Health

This section addresses the socio-cultural norms, beliefs and practices that shape the Rohingya’s health outcomes. It is important to note that a great majority of the poor health outcomes are not related to culture, but to a lack of basic infrastructure in the camps (safe water and sanitation), health service provision, unaffordability of services, restrictions of movement and other ‘material’ constraints that have little to do with socio-cultural norms.

Access to health

IDP camps and villages in Arakan only have limited capacity for primary care, basic emergency obstetric care, and basic emergency services (Rakhine Advisory Committee). Medical treatment is expensive, and people lose their savings and possessions when illness or death occurs (Kadi Farzana). The restriction of movement by the system of permits means that people are denied access to health facilities, even in the case of emergencies (Mahmood). Rohingya in IDP camps can only use the clinics within the camps, and they are not permitted to access the township hospitals, despite being close to the camps (WHO 2015). Permits are necessary to leave the village or IDP camp, they take months to be processed and too costly for people to afford (Lewa 2009, Mahmood et al 2017). People need to apply for a costly travel permission even to travel to a poorly equipped clinic for example in a large town such as Sittwe. Referral of critically ill patients is often denied (Lewa 2009, Mahmood 2007).

Clinics in Arakan state are normally manned by Rakhins or Burmese staff, and there is a problem of communication, both in terms of language (since they do not speak Rohingya and would need translation), and the Rohingya are treated with contempt, or even refused treatment (Rakhine advisory committee). In Bangladesh, there is not enough staff to meet the demand, and there are not enough female personnel health staff in camps for women to

discuss their health problems. Further, there are reports of some male staff harassing women, which exacerbates these anxieties (UNHCR 2007: 10).

Even outside of Myanmar, Rohingya refugees may hesitate to seek biomedical health care "due to reasons such as fear of being detained, lack of access to health care services and high medical costs. As many of the Rohingya adults have low education level or never attended school, they may have difficulty to understand the health information conveyed by health professionals" (Sok Teng and Zalilah 2011: 47).

Alternative health provision

In a context in which there are only 5 health workers per 10,000 people in Rakhine (Advisory Commission for Rakhine State 2007), it is very common for people to seek treatment through home remedies and consulting with alternative medical providers (ACF 2015: 21)[15].

- Home remedies - most of the elders have knowledge of medicinal plants and have been known to use them in their native Arakan as well as in the forests around the camps in Bangladesh for common problems (Khan et al 2009). However, this knowledge seems to be being lost amongst the younger generations in the camps (ibid).
- Local healers who use medicinal plants, called *boiddah, kabiraj or hakime,* collected from adjoining forests are consulted for more complicated issues (ibid).
- *farar dorktor* or village doctors are often shopkeepers without medical training that sell medicines and also give advice on illnesses and treatment.
- Healers who address possession by *jinn* (spirits) through the administration of remedies (according to medicine books called *bóddo*)
- Faith healers that get in contact with another *jinn*, and then seek guidance from it in order to administer remedies.
- Faith healers can also use amulets, used by children (around the neck or the hips) and adults, particularly pregnant women.
- Faith healers also address evil eye by someone who bears the client "ill will"

Rohingya understandings of disease and health are intertwined with spirituality and religion and other spheres of life, such as the economic problems. Faith healing is often understood within the sphere of Islam and accompanied by prayers. Economic difficulties, malnutrition, mental health issues, can be attributed either to *jinn* (spirits) or evil eye.

Evil eye is attributed to "lack of enthusiasm, loss of appetite, impossibility to sleep." (ACF 2015). In the case of *jinn*, they are attributed ailments such as "polio, epilepsy, continuous or repeated crying as well as over-frequent urination".

In the camps, people combine the use of (biomedical) health services provided by the camps (in the case of Leda camp, by Islamic relief) with visits to local religious healers (Palmer 2011). According to Palmer, those Rohingya from higher social strata are more likely to prefer Western medicine to alternative medicine.

[15] Please note that healers can use more than one method.

There is an element of fatalism when addressing illness: “Muslim Rohingya are unlikely to see longevity as a motivating factor; as with other Muslims, lifespan is seen as preordained by Allah.” (Queensland State and Metro South Health 2015: 6).

When seeking treatment and deciding which provider to use, it is decided by the husband’s family, in which often the mother-in-law and the husband are the decision-makers deliberating who to attend, whether the clinic, the traditional healer or the midwife (in the case of pregnancy related issues).

Water and sanitation

In terms of water and sanitation, the relevance of socio-cultural norms is significantly less. Clean water and appropriate sanitation as promoted by humanitarian agencies are in line with *hadiths* (precepts referring to the words, actions, or habits of the Islamic prophet Muhammad) that recommend piped and underground water sources and forbid contaminating the area surrounding a water source (for example through open defecation) (ACF 2015; 2017). There are only a few factors to take into account.

- To uphold Purdah, it is preferred if latrines are gender segregated
- Latrines should be built on a north-south axis, because it is not allowed to defecate facing west (towards Mecca).
- Children under 5 years old in rural areas tend to be allowed to OD around the house (ACF 2017)
- According to ACF 2015, people believe they are more susceptible to being harassed by *jinn* when they are in the impure setting of latrines, and hence say prayers when they use them. They also speculate that people are reluctant to have latrines close to their home for that same reason.
- Housing structures should allow for a sense of ‘privacy in the home’
- Since women are at risk of gender violence, appropriate lighting and security in the camps is paramount.
- Water points should allow for the fact that women pray at home, and hence require water for ablutions in the home.
- There should be water points available near mosques for ablutions.
- Water points for handwashing should have soap, and people would wash their hands before and after going to the latrine, provided there are appropriate nearby washing points with soap.

Reproductive health: Contraception, Pregnancy and birth

There is an ambivalence towards contraception, both in Islamic jurisprudence and in people’s everyday practices. According to the Quran, it is a duty of a family to welcome each child to the world because they are a gift of Allah, but at the same time, it is sinful for a family to bring a child into the world if they cannot provide for him or her (Islam also forbids the preference of one gender over another). Hence the role of sterilisation and contraception can be debatable in religious terms. In practice, many Rohingya women do use contraception. For example, Palmer reports of women in Leda camp being “pleased to receive contraception supplies from Islamic Relief, a practice which the organisation justifies in reference to Islamic teachings and scholarly works.” (Palmer 2011). More than half of respondents in Cox Bazaar used contraception (Khan 2016)

Pregnancy and childbirth matters are male-dominated, either directly through the husband or through the influence of the mother-in-law. In Kane’s words in her contribution:

> "the decision to freely take decision with regards to family planning or birth control, sexual practice or family or marital relations is not women' prerogatives but rather a decision of their husband or other male relatives."

The average age of pregnancy is around 16-20 in Rakhine state (SCI 2015: 15). Decision-making about the mother's behaviour in pregnancy: activities, foods to be eaten and avoided, etc. is in the hands of the mother-in-law. Mothers-in-law supervises the health of the mother and child and if there are issues, she uses traditional remedies or contacts healers or health clinics accordingly. As mentioned before, pregnant women use amulets against evil eye during pregnancy.

Rohingya women respect the opinion of midwives, hence mothers-in-law and midwives are good interlocutors to discuss issues around sexual and reproductive health, together with mothers and would-be mothers. The great majority of reproduction falls outside the formal health service (Khan et al 2016). According to Save the Children and Khan et al 2016, young girls have little knowledge of how their bodies work in terms of reproduction. Kane, in her contribution, states that health services are dominated by a male vision, and advocates for listening to the maternal health demands of women.

Miscarriage can be understood as a product of a *jinn* possession. Another belief is that women are better suited to have children in their teens rather than in their twenties (SCI 33).

Rohingya women in Rakhine and in refugee camps in Bangladesh depend on midwives (or traditional birth assistants (TBAs) to deliver their babies. The majority of deliveries take place in the home. Those women who delivered in formal refugee camps are given a home delivery kit (gloves, sheets and soap) to enhance hygiene, whereas women refugees in informal settlements would not have the access to those health services (Queensland health 2009). A great majority of women start breastfeeding before half an hour after the birth (Khan et al 2016). Boys are breastfeed until the age of 2, and girls may be breast feed longer, until 2.5 years. Please check Annex 2 for further information on food restrictions in pregnancy and breastfeeding.

There is traditionally a 40 day wait period for physical and sexual activity post-partum. There are restrictions on what the baby can eat until 6 months postpartum (see Annex).

The two child-policy and the law enforcing a 36 month time lag between births has had terrible effects on women's health, who have been forced to take up backstreet abortions - 1 out of 7 Rohingya women have had abortions (Mahmood et al 2017) - performed by untrained staff in unhygienic situations. Further, movement restrictions mean that they cannot seek obstetric care in health facilities, hence it is not surprising that maternal mortality in Arakan state is double that of Myanmar as a whole. The two child policy also means that there are over 60,000 undocumented Rohingya children in the State (ibid).

Nutritional health

"The nutritional status of children in Rakhine State is the worst in the country, with 38 percent of children stunted and 34 percent underweight. Widespread poverty, exacerbated by conflict, has resulted in protracted trends of both acute and chronic malnutrition across the state" (Advisory Commission for Rakhine State 2007: 42) These figures conflate Rakhine Buddhists and Rohyingias, hence the expectation would be that the Rohyngia rates would be even worse.

The rates of malnutrition do not differ between boys and girls. The presence of girls is higher in feeding programmes, because boys are considered to be stronger. There is a sense of

shame of having a malnourished child (*ganda* child) because it signals that the family has not been able to care for him or her.

The language of malnutrition is important for communication, people speak in two ways about child malnutrition: there are two kinds of "illnesses" which relate to the condition of under-nutrition. One is *léça biaram* (thin illness), designating a slimming disease, and the other is called *tom zu (?) biaram,* which designates a disease provoking a loss of strength. Both diseases are attributed to the action of *jinn* (spirits)" (ACF 2015).

Nutrition outcomes are determined by the level of household income, education and size. These factors are more important than social and cultural factors (what Sok Teng and Zalillah call socio-demographic factors). Other important factors are dietary diversity (also linked to incomes), immunization levels and childhood illnesses.

The 'typical' Rohingya diet is mainly "made of rice, *ngapi*/chillies, accompanied by fish for additional curry, plus vegetables. Fish is the main source of protein" (ACF 2017: 3). When consulted about the contents of food baskets for humanitarian provision in Cox Bazaar, ingredients which refugees wanted to add the basic list of rice, pulses, vegetable oil, salt, sugar and blended food were: dry fish (or other animal origin food), vegetables and chilli (see section on music - those probably are the ingredients evocative of home). Staples e.g. rice and pulses should be the same type that is normally consumed by Rohingya (WFP and UNHCR 2012).

Mental health status shapes the quality of childcare. Poor mental health status due to trauma and PTSD and lack of hope and opportunities for the children, derives in an unconscious lack of childcare.

Psychological health, Trauma, PTSD

Amongst the Rohingya, who have undergone sustained violence, discrimination and forced displacement for decades, there are "high levels of mental health concerns: posttraumatic stress disorder (PTSD), depression, somatic complaints, and associated functional impairment." (Riley et al 2017). For two decades in camps in Bangladesh, there have been "minimal psychosocial services and lack of specialized mental health interventions" (Riley et al 2017: 304).

Women were more likely to suffer PTSD, and older people and those who had experienced more traumatic events were more likely to have PTSD. Most common traumatic events were "confiscation or destruction of property (75%), beating (56%), extortion or robbery (55%), and being forced to hide (52). (…) [Also] torture (40%), physical abuse by a spouse or other family member (27% of males and 38% of females). Three percent of women and 17% of men surveyed reported experiencing rape or other ''forced sex.'[16]'. These PTSD symptoms are triggered with environmental stressors such as "problems with food, lack of freedom of movement and concerns regarding safety", which are common in the camps. Improvements in these three environmental triggers will increase the wellbeing of refugees with PTSD (315-316). It is important to note that trauma expressed differently in different socio cultural contexts: we must be careful to just assume PTSD symptoms as per American Diagnostic and Statistical Manual of Mental Disorders. The humanitarian intervention must assess and understand how people are experiencing and responding to the social and personal suffering and violence from their point of view.

[16] Riley et al 2017 consider these lower figures as a result of underreporting by women and would expect for figures to be higher amongst women than amongst men.

Depression in the camps, however, is not correlated with a history of trauma. It is still more likely to occur as a result of environmental stressors i.e. lack of food security and safety, and occurs more frequently to women and to older refugees (Riley et al 2017: 318).

As explained above, some Rohingya use the idiom of (spirits) to speak about mental illness, a common occurrence in Islamic countries. In Riley's survey in two camps in Bangladesh: "Participants endorsed several symptoms over the past month, although at relatively low frequency: 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%)." As mentioned above, healers make amulets with herbs combined with verses of the Quran to address *jinn* possession associated with these mental health symptoms (ACF 2015). Perhaps a way of communicating solutions or ways to mitigate mental illness is through the idiom of *jinn*. ACF, for example, sees a role in religious leaders in delivering "key messages such as the necessity to pay more attention to depression among mothers. Such messages should be well designed in order to maintain the spiritual dimension of depression which is linked to the action of malevolent spirits or the evil eye" (ACF 2015: 34)

Protection

Whilst protection issues are a fundamental concern amongst Rohingya, including issues such as violation of rights vis-a-vis admission, registration and recognition of refugees, arbitrary arrest and detention, security and the administration of justice, health and food security, accommodation, education and right to own property[17]. According to SCI: "key protection issues in the country include abuse, neglect and/or exploitation, being trafficked, exposure to HIV/AIDS, street labour, lack of parental care, discrimination and recruitment into the armed forces. Lack of adequate legal and institutional structures and support as well as the particular socio-political climate of the country exacerbates the issues. In the case of Rakhine State where children are exposed to natural disasters, such as flooding, conflict and poverty, protection issues abound." (SCI 2014: 2). Children, who make up half of the total refugees in Bangladesh, are particularly vulnerable to these abuses and human right violations (D'Costa 2017). Another issue is the precarious status of refugees outside the formal camps, living in informal settlements in Bangladesh or other host countries.

A rights-based approach to these issues would yield interesting gaps in the humanitarian response. However, this paper will cover only cover those protection issues that are shaped or influenced by socio-cultural norms.

For the population in general

As described above, there is a strong idea of a 'homeland' in Arakan state and people have a will to eventually return to their homeland (Farzana 2011, Groslund 2016). However, Rohingya move to Bangladesh seeking safety. Though there may be hopes of a return to their homeland in Rakhine state, this would only be once their safety and living conditions is secured. There are negative experiences of refoulement in the period 1992-2005 in which the Bangladeshi government sent back over 235,000 Rohingya to Myanmar, many of them involuntarily (Mahmood et al 2017). Hence the 'right of return' has to be paired with the realisation of their rights and safety (including citizenship status) in Rakhine state. If this cannot be guaranteed, the humanitarian response should respect the refugee's request to stay in the host country.

[17] For an insight into the human rights violations against the Rohingya please read the recent OHCHR report (OHCHR 2017).

Even within the camps, there is lack of awareness of the risks to migration (kidnapping, forced labour, and so on), although there is awareness that there is trafficking taking place and sexual exploitation of children (Akhter and Makusabe 2014). There is space for C4D activities highlighting the risks of migration.

There are concerns about the accountability of camp authorities and *Mahjees* (refugee leaders), some of which were reported in 2007 to be behind arbitrary arrest and detention, arbitrary taxation and sexual and gender- based violence (UNHCR 2007). It is not clear in the literature how these accountability issues were address.

Differences within populations (to identify gaps)

(i) Pregnant women,

(see section on pregnancy above)

(ii) Children[18]

As part of disciplining children, beating children is common place.

When violence against children occurs, it doesn't always transcend beyond the household: abuse towards children 'is for the family to deal with it'. Children do not always use or trust the "child-friendly" reporting system put together in camps. Reasons they do not report abuse to camp authorities include: lack knowledge of procedure, fear of repercussions and the fact that perpetrators are sometimes powerful community members (SCI 2014).

From an early age, children are socialised into their respective gender roles. Girls are expected to stay at home, to help in housework and childcare until they are ready to get married, whilst boys are socialised into roles in the public sphere, such as agriculture and fisheries. As mentioned above, upholding purdah is only possible for those who can afford it.

Hence child labour is an ever increasing reality. Although it has always played a role in agricultural societies in times of planting and harvest, in the case of Arakan and the refugee camps, girls and boys are increasingly relied on to work to ensure the household income. When children do work, they often accompany their parents (Masood 2016).

Girls are kept from education when they reach puberty for reasons of purdah. The pressure is societal, not simply the influence and decision of the parents. The elders of a camp may disapprove of a young woman seeking education, rather than staying home (Suryanarayan 2016).

Marriage is traditionally perceived to be the safest way to secure a girls livelihood. The difficult circumstances in the camps may mean that parents push their daughters to get married earlier than they would have otherwise, because they cannot afford to provide for them longer (ACF 2015; WFP and UNHCR 2012). In a UNHCR survey conducted in 2016, 85 women who had migrated to India, Malaysia and Indonesia were interviewed: 59 percent had married under the age of 18 (UNHCR 2016).

As mentioned above, polygamy is also becoming more frequent, which may cause neglect to women and their children. The rise in polygamy is directly correlated with the increase of male migration (a scarcity of males) to other regions or third countries to seek employment, and the decrease in economic opportunities for households to keep afloat (ACF 2015; WFP

[18] I didn't so far have enough information to differentiate between the cohorts 0-5 and from primary school age –with the exception on those mentions around health and nutrition-, so I've created a unified category for children)

and UNHCR 2012: 25). ACF 2015 states that when resources are very low, women tend to prioritise their own children, and that older wives are often neglected vis-à-vis the younger ones.

When children do work, girls often carry out (and prefer) “tailoring, household work and basket weaving”, whereas boys’ common jobs were “fishing, livestock herding and distribution of items such as charcoal or rice”. When children do engage in paid work, it requires their whole day, hence making attending school or children-specific activities very difficult (SCI 2015: 21-22).

Spaces for children to play in the camp should be made available (contribution Masood).

It has been reported that large numbers of children do not attend Child-Specific Groups[19]. However, Mirante’s contribution states that child-centred activities are overcrowded. Perhaps this means that there is a double issue of a number of children not attending but the total influx of population is so high that the services are overloaded? As mentioned above, child labour and purdah, together with fear of children’s safety make attendance less likely. Masood, in her contribution, also attributes the lack of participation in education activities as a sign of parents seeing their status of temporary, thinking they will return to Arakan soon. Parents are unaware of the role of these groups in terms of child protection (SCI 2015). SCI reports that allowing youngsters to accompany their children siblings to these groups has been very useful. They recommend that one way forward to ensure girls are able to attend activities, is to create mother-and-daughter activities.

(iii) Adolescents

Understandings of what it means to be young are context-dependent. As it occurs elsewhere, it is not only a question of age e.g. 12-18, but the situation people are in. A young person who is married will be considered an adult, and so on. The recommendation for organising youth activities is to make explicit which demographic the activities are relevant to, both in age and in social status.

The same issues prevent adolescents from participating in youth protection activities: “migration, lack of parental permission, and in particular child labour may be the causes behind youngsters’ low participation rates in youth activities”. In the research carried out by SCI in Arakan state: “

> Segregation, restricted access to social and physical infrastructure and resources, household poverty, mentalities, hopes and fears all combine to drive youngsters into early marriage (especially young women), migration (voluntary, smuggling and trafficking) or employment. (The problem is not type of activities or timing) (SCI 2015:1)

Young boys (12- 18) are kept from attending activities for youth mostly due to casual or seasonal labour. Girls are kept from attending when they reach puberty due to purdah, through which they need to stay home to help their families. Traditionally, boys and girls are segregated from puberty. Time consuming household chores may make girls miss programmed activities, flexible times may partially address this.

[19] For the purpose of protection, activities (leisure and educational) are organised for children-only and youth only groups in the camps.

It is important to note that for children and young people helping the family is important, hence they will voluntarily seek employment out of duty and obligation towards their family (SCI 2015; 23).

There is an important point in terms of decision-making. A disparity has been reported between adults and youngsters in terms of who they consider to be the decision-maker in the family. Adults think it is the father, yet youngsters think it is the mother (SCI 2015: 11). This is because young people turn to their mothers for advice.

(iv) women of childbearing age

The population control measures of allowing a maximum of two children imposed by the Myanmar state in 2015 and the requirement of permits for marriage may mean that refugees in Bangladesh take the chance to get married and have more children, hence programming should account this. Further, the ban on third children has meant a significant number of children are unregistered by the authorities.

In Arakan state, women face significant challenges due to the disappearance and migration of men. This increases the workload of women. Women are driven to become breadwinners, yet the circumstances are adverse to that: they have little access to credit or livelihood opportunities (Advisory Commission for Rakhine State 2007). Further, gender-biased inheritance laws means that when a person dies, male descendants are allowed two parts of the inheritance for every one part that a female descendant receives (ACF 2015). When pursuing work opportunities outside the home, the restrictions on movement and their low levels of education mean that their choices are very few, other than in their immediate neighbourhood (Advisory Commission for Rakhine State 2007, page 21). Female headed households are amongst the most vulnerable in the camps, often incapable of achieving the minimum family income to survive.

Men are traditionally the primary decision-makers in the nuclear family, and it is the husband who mediates between the mother-in-law and the wife (as we saw above). In Kane's contribution:

> "Women of the Rohingya, as others are also facing patriarchal domination over their private and public life and have thus unbalanced gender relations that provide supremacy of the conduct of family affairs by the male counterparts be they father or husband, or other significant male relative. Women religious beliefs and cultural practices have a significant impact on their social role within the family and in their community. The unequal gender relation that privileges men leading place in private sphere restricts free choice and decision making abilities of women."

Domestic violence is mostly understood as physical violence, and women do not necessarily perceive psychological abuse as violence. When domestic violence is perpetrated, it is often by husbands and not by other members of the family-in-law. Domestic violence is perceived as a "family affair", to be solved by the family alone.

Sex and Gender violence is commonplace both in Arakan state and in the camps. The Myanmar military has been accused of using rape as a weapon of war (Al Jazeera 2017) and UNHCR found in 2007 to be a common place occurrence in the camps and in informal refugee settlements "with the *Mahjees*, local villagers and police as the common perpetrators" (UNHCR 2007: 9). The position of power of those representatives makes redress and prevention a priority. Their cross-border journey is also fraught with dangers, as women are more likely to be exposed to human trafficking (Al Jazeera 2017).

In the camps, there are significant challenges maintaining privacy, particularly for women. The make-up and sizes of housing structures are inappropriate and can be a source of stress for women. In the same vein, latrines and the surrounding areas and the walk from the homesteads to the latrines are not adequately lit.

Recommendations

1. Finding trusted and respected stakeholders for C4D

In populations who have experienced long-term systemic violence and marginalisation it may be difficult to identify trusted and respected authority figures. Self-appointed or formal community leaders are not necessarily the people whom have the most legitimacy and influence, indeed they may be associated with previous abuses of power. The experience in the Ebola crisis showed that it is worthwhile and possible to conduct a quick survey in the community to see whose advice people trust (and on what issues), and contrast it with the usual 'community representatives'. That said, it is useful to understand the social structures that existed in Arakan Rohingya communities as these people and categories are still likely to be useful entry points for engaging with the community.

These potential stakeholders could be:

- *Mullahs, Imams* and *Mulvis* are simultaneously able to command/motivate resources from the community (financial resources or labour, although scope for this decreases when resources are low) and they command the respect of many Rohingya. Messages could be transmitted through these religious figures. Since women do not attend the mosque, contact with women could be through women *hafes* and midwives (see below).
- *Shodor (traders and financiers) and members of the village committes (sómaj):* are the enactors of community solidarity and redistribution (*Zakat* and other forms of charity) and would be good vehicles for awareness and key messages regarding best childcare practices (and indirectly protection issues) especially toward males in the community.
- *Traditional and spiritual healers*: alternative practitioners who work with herbal remedies, shopkeepers who sell drugs and give advice, doctors who heal *jinn* possession and use prayer, are people on whom Rohingya have placed their trust.
- Female *Háfes* – women who have memorised the Quran and who educate other women on religious matters and on issues to do with marriage and proper behaviour. *Hafes* would be good interlocutors to engage for communication and to spread messages around sexual and reproductive health.
- *Midwives*- in terms of sexual and reproductive health.

Messaging will have most impact in the Rohingya language. Whilst Chittagonian is intelligible by Rohingya speakers, it is best to communicate in the native language. Since many Rohingya are not literate, popular culture such as poems and music (Taranas) could be used to transmit messages). It would be valuable to identify if there are musicians and poets in the camps.

In terms of messaging, there are variations depending on the location, but overall there is a preference in receiving messages through face-to-face interaction. People report they trust religious leaders and NGO workers as sources of information. Men are less likely to want to participate in focus group discussions, whilst women and youngsters (female and male) are

more open to receiving information through them. Women preferred to be contacted through face-to-face encounters and focus groups to other forms of contact. Men and young boys prefer also face to face contact, but also information through the workplace and messages through TV, megaphone or mobile phone (C4D reports from Balukhali and Shamlapur).

2. Working within the idiom of Rohingya Islam

Rohingya are religious, and consider their capacity to practice Islam as essential, on a par with other humanitarian priorities. Public consultation should take place when designing the mosque, allowing for the design to house the appropriate number of people, have the minimum structural features to meet Islamic precepts (orientation, pulpit and niche). Water should be made available for ritual washing (*wudu*), both in the mosque and for women who pray at home.

Purdah is a source of pride and family honour. The camp should be organised with a sensitivity to purdah so it is possible for women to uphold it should they want to. This could include segregation of latrines, women or girl only activities, chaperoning, and so on. Purdah is inevitably intertwined with security concerns about gender violence, therefore it is important to guarantee appropriate policing, accountability of those guaranteeing security, appropriate lighting and provision of services in areas that are not remote. To increase young girls' presence in activities, carrying out girl only activities or mother-daughter activities could be useful.

The relationship between the mother-in-law and the mother (mediated by the husband) has a crucial impact in terms of maternal health and child nutrition. Succeeding in creating a productive discussion about humanitarian issues between mother-in-laws and wives would be very useful in promoting positive care practices.

3. Health: Working with different kinds of care-providers

Most constraints around health have little to do with socio-cultural norms. Availability, access, cost, and lack of staff are the fundamental problems people face. Access to health in Arakan state was so difficult that new people in the camps may not realise that they are entitled to health services there and hence should be informed of this.

In Arakan, there are significant problems of inter-cultural communication, and a lack of understanding of Rohingya culture. To avoid a similar situation in the refugee camps, humanitarian interventions need to build health staff skills in interpersonal communication and sociocultural understanding to ensure people trust the service providers. In the camps, there are not enough women staff, an effort should be made so as Rohingya refugee can seek care from women health staff if they wish to.

There is a need to recognise the role of religion and religious beliefs and build on those –for example, working with religious leaders in promoting healthy behaviours.

Communication initiatives should engage with pharmacists and traditional and Islamic healers to disease prevention and control, getting messages through them, as well as providing health training for referral to biomedical clinics when necessary.

Water and Sanitation

- To uphold Purdah, it is preferred if latrines are gender segregated
- Latrines should be built on a north-south axis, because it is not allowed to defecate facing west (towards Mecca). The community should be consulted when placing latrines
- Since women are at risk of gender violence, appropriate lighting and security in the camps is paramount, including in the latrine area
- Water points should allow for the fact that women pray at home, and hence require water accessibility for ablutions in the home.
- There should be water points available in/near mosques for ablutions.
- Water points for handwashing should have soap, and people would wash their hands before and after going to the latrine, provided there are appropriate nearby washing points with soap.

Reproductive health

Háfe women, when available, are good interlocutors to reach women to discuss reproductive health. They are often consulted "on personal matters, such on how to behave with ones husband, how to behave when pregnant, how to deal with the first menstruations, etc." Together with midwifes (TBAs), they can deliver messages in all sectors: nutrition, health, wellbeing and water and sanitation.

Contraception can be justified in Islamic terms (and hence it is sometimes overlooked/allowed by religious authorities), in terms of the responsibility of a family to provide for each child that is brought into the world (in opposition to the precept of welcoming every child as a gift from God). If circumstances make this impossible then contraception may be tolerable. Messages about contraception should be sensitive to the the Rohingya's previous experience of heavy-handed state-imposed population control in Myanmar.

Health and administrative services in the camps have to prepare to the fact that women will be likely to get married and/or have children as they are now free from the two-child policy. Similarly, there should be obstetric care available to deal with the sequels of backstreet abortions.

Nutrition

Nutrition outcomes are primarily determined levels of household income, education and size. Social and cultural factors are less important that these socio-economic factors in shaping nutrition. Other important factors are dietary diversity (which is also linked to incomes), immunization levels and childhood illnesses. Socio-economic factors may be hard to address in camp environments but at least it means there is not any major cultural barriers, including significant gender biases in feeding.

It should be possible to ensure diets are diverse and culturally appropriate by discussing the contents of food baskets with refugees (e.g. what pulses to include, what ingredients, etc.).

Mental health

Mental health issues are spoken sometimes by patients of as *jinn* possession. Knowing this will help in terms of diagnosis, but also in how the solutions are explored, with therapy (and treatment) framed in the same idiom of *jinn* (Johnsdotter et al 2011).

4. Protection: safe spaces and attendance

Special efforts need to be made to encourage participation in decision-making for camp affairs, particularly to involve women and girls. Whenever possible female fieldworkers (e.g. UNHCR) should be the ones to interview women about their priorities and experience (contribution Farzana).

As issues of trafficking and migration stem from family obligations and constraints there is a need to inform and engage the family as a whole around the risks of associated with these activities.

Children's attendance in supposedly child-friendly spaces and activities is made difficult by child labour and purdah. Child labour can only be addressed in terms of ensuring adequate household incomes in the camp. In terms of purdah, as noted above, girl-only activities, chaperoned activities (where an older sibling accompanies the child) or mother and child activities should be explored.

Young people tend to rely on their mothers for advice and hence mothers are important communicators of safe behaviours.

Polygamy and child marriage is not only an element of culture but it is an adaptation to curtailed livelihood opportunities in the camps. Creating productive forms of employment or flows of income may have an important indirect impact in terms of child marriage and polygamy.

The mechanisms to report abuse (of children, domestic violence and so on) must be accountable and safe, and deemed trustworthy by camp dwellers. Camp authorities should be accountable to their behaviour, and there should be formal arrangements in place so that they do not have discretionary power. In devising such systems efforts should be made to consult the views of vulnerable groups and to identify who they would trust.

Discussions on abuse and domestic violence should make clear that 'violence' includes not only physical violence and injury, but also verbal and psychological violence.

Annexes

Annex 1. List of contributors

This paper draws upon an extensive desk review of more than 50 peer-reviewed articles, research papers and humanitarian reports. It also synthesises the contributions of the regional experts below who were interviewed or sent email responses. Contributions from these experts are indicated in the text as 'Contribution [surname]' to differentiate them from written sources. Consultation with experts allows for the inclusion of up-to-date insights and a broader range of perspectives that are not available in published literature.

Iftekhar Iqbal

Kazi Fahmida Farzana

Asma Masood

Carlos Sardina Galache

Edith Mirante

Amal de Chickera

Aissata Kane

Gabrielle Aron

Wakar Uddin

Elzbieta Gozdziak

Pauline Oosterhoff

Annex 2. Food interdictions during pregnancy and breast feeding

Source: Action Contre la Faim 2015

Boys are breast fed until the strict limit of 2 years old. Girls are breast fed until the limit of 2 years and a half, this limit not being strictly followed. Besides, after 6 months, boys are systematically fed with additional food, while there is no clear limit for girls. This seems to be related to the necessity to give strength to the boys given the fact that mothers tend to value more boys than girls (see infra). Hence, in crisis time, boys are likely to receive more additional food after 6 months, while girls would be only breastfed.

There are no food restrictions for pregnant women in Muslim communities except from beef.

Respecting Ramadan during pregnancy brings double merit for the woman added to the fact that they can touch and access the Koran because they don't have their period. To our knowledge, a great proportion of pregnant women therefore fast during Ramadan for this reason.

Breastfeeding mothers fasting during Ramadan don't stop breastfeeding during the day.

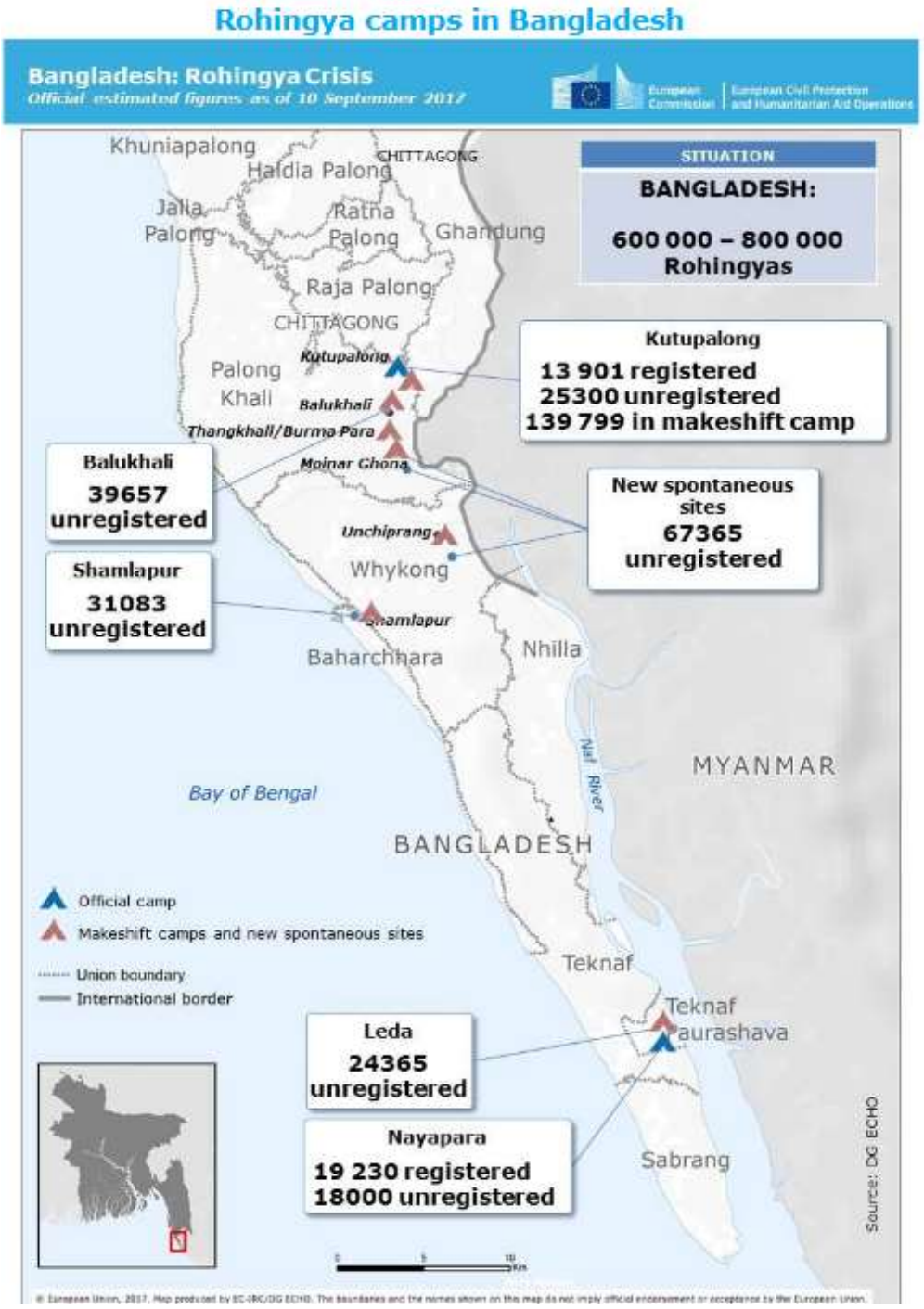
Pregnant women shouldn't have any contact with rainwater in particular, and with cold water in general. Hence they must only drink hot water/tea. This also applies to the 40 days after birth.

Child is breastfed for the first time only after being given a Ghusl (ritual washing of the whole body) and after receiving prayers (azan/tawkbir) from the Mullah (2 for the boys, expressed loudly, 1 silent for the girl). This prayer may last between 15 min and 1 hour depending on the blessings and the status of the family. A well organized birth – the Mullah is ready and arrives right after the birth – may be quick between rituals and the first breast-feeding. However it arrives that unexpected births delay the time the newborn will receive his/her first breast-feeding if the Mullah cannot be reached straight away.

After birth, during 40 days the mother eats mainly plain rice and chillies. Fish can be consumed if dried yet it remains an expensive food. Vegetables, beans and other common foods are prohibited during this period. Dry food, especially dried chillies, are believed to help the uterus retract and fasten the mothers' recovery. Besides, some mothers use dried chillies to apply on the child's navel to dry the remains of the umbilical cord. The umbilical cord is generally cut with a razor blade first disinfected with fire.

Annex 3. Main refugee camps in Bangladesh

Source ECHO 2017



Annex 4. Glossary

ganda	malnourished child
hadiat	gift
háfes	People who have memorised the whole Quran
jinn	spirits
mullah	Quran scholars who can lead prayer in mosques
mulvis	Heads of madrassa religious schools
musk'rat jamaat	pilgrim tours teaching Islam to surrounding communities
Nasaka	Myanmar border police force
purdah	the practice of screening women from men or strangers
shodor	trader/financier respected in the community
sómaj	village Islamic society
tarana	Rohingya song
wudu	ritual washing, ablutions
zakat	Zakat is the compulsory giving of a set proportion of one's wealth to charity.

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