RAPID MENTAL HEALTH AND PSYCHOSOCIAL NEEDS

ABSTRACT
This rapid Mental Health and Psychosocial Needs Assessment identifies the main individual, family and community factors affecting mental health and psychosocial wellbeing of the Rohingya refugees displaced in Cox's Bazar in the camps of Kutupalong, SS and Leda.

IOM-Cox's Bazar - MHPSS coordination
IOM, March 2018

BACKGROUND

Since 25 August 2017, an estimated 671,000 Rohingya have crossed into Bangladesh fleeing violence in Myanmar's Rakhine State, increasing the total Rohingya population in Cox's Bazar to over 831,597. New arrivals are living in spontaneous settlements with increasing need of humanitarian assistance, including shelter, food, clean water, and sanitation. The Rohingya influx in Cox's Bazar has put pressure on the host Bangladeshi community, particularly in the districts or *'upazilas'* of Teknaf and Ukhia where the Rohingya now constitute at least one third of the total population.

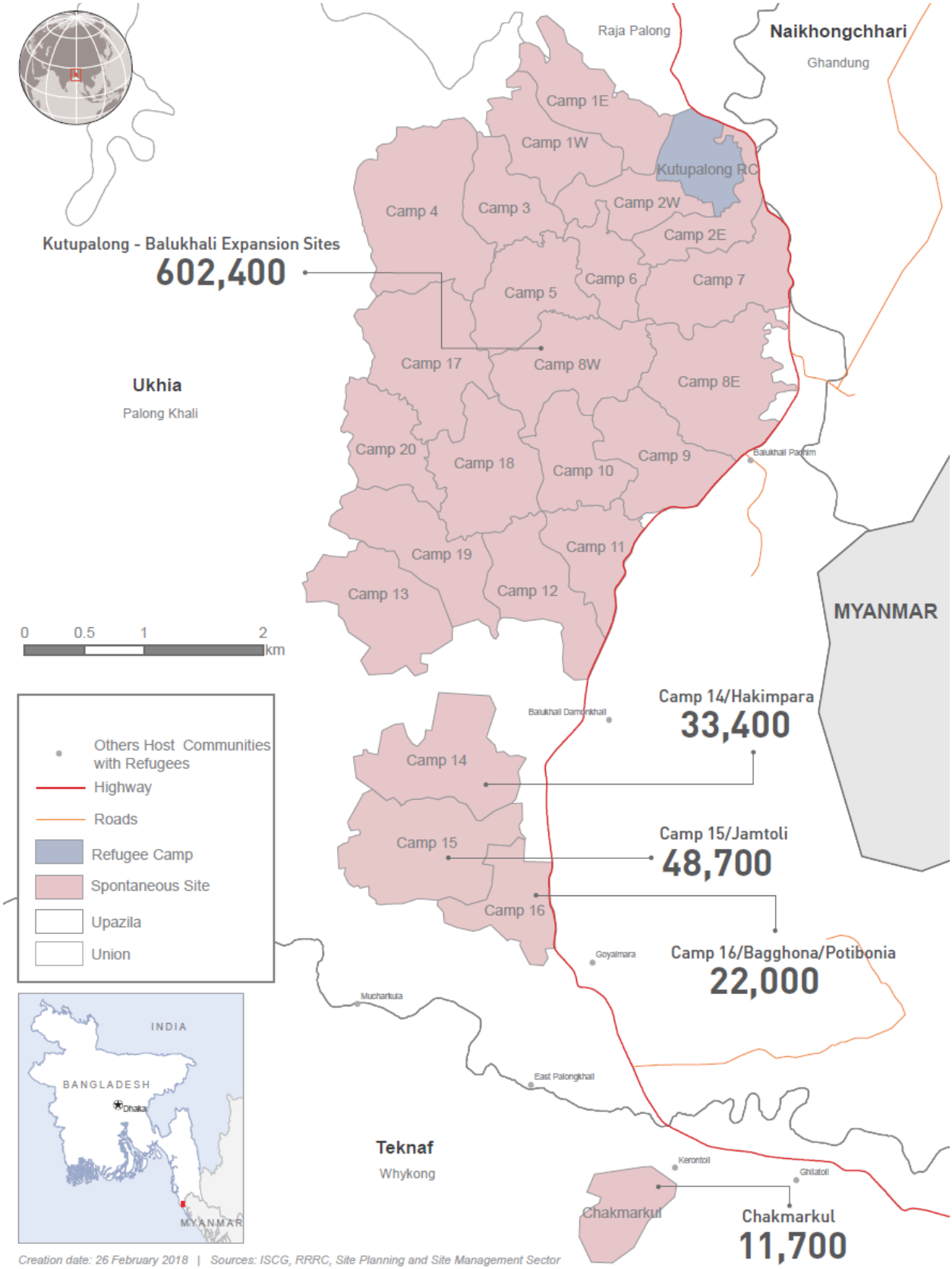
Cox's Bazar is one of 20 (out of 64) identified 'lagging districts' of Bangladesh, and Ukhia and Teknaf areamong the 50 most socially deprived districts in the Country (out of 509). Difficult terrain, bad roads and insufficient infrastructure contribute to poor living conditions. A lack of cultivatable land and consequent dependence on markets for food drive high levels of food insecurity, and vulnerability to price fluctuations and food availability.

In the period of 4th January-12th February 2018, the International Organization for Migration (IOM) initiated a rapid assessment of Mental Health and Psychosocial Support (MHPSS) needs of the population, to identify the main factors affecting mental health and psychosocial wellbeing of the Rohingya refugees and displaced populations in Cox's bazar in the camp sites of Kutupalong- 2W , SS- 10 and Leda. This rapid assessment investigated their emotional suffering, as well as family and community issues, resilience factors and spontaneous responses. beyond a focus on "trauma", to look at a wide range of people's responses to adversity (Papadopolus, 2011).

MAIN OBJECTIVES

- Identify mental health and psychosocial needs of Rohingya refugees displaced in 3 main camp sites in Cox's Bazar
- Explore community's perceptions and understandings of mental health and psychosocial needs, as well as coping strategies and resilient responses
- Map the availability and accessibility of MHPSS services.

STUDY SITES



Creation date: 26 February 2018 | Sources: ISCG, RRRC, Site Planning and Site Management Sector

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations

Map 1- Cox's Bazar refugee population in Ukhia- ISCG Feb 2018

Data collection took place in Kutupalong mega camp, SS and Led. These camps were chosen due to population's size and to complement a baseline NPM site assessment that was being conducted in parallel, as well as the main presence of IOM health facilities.

General profile of camp sites

Kutupalong- 2W- with 25,200 and 5,800 households:

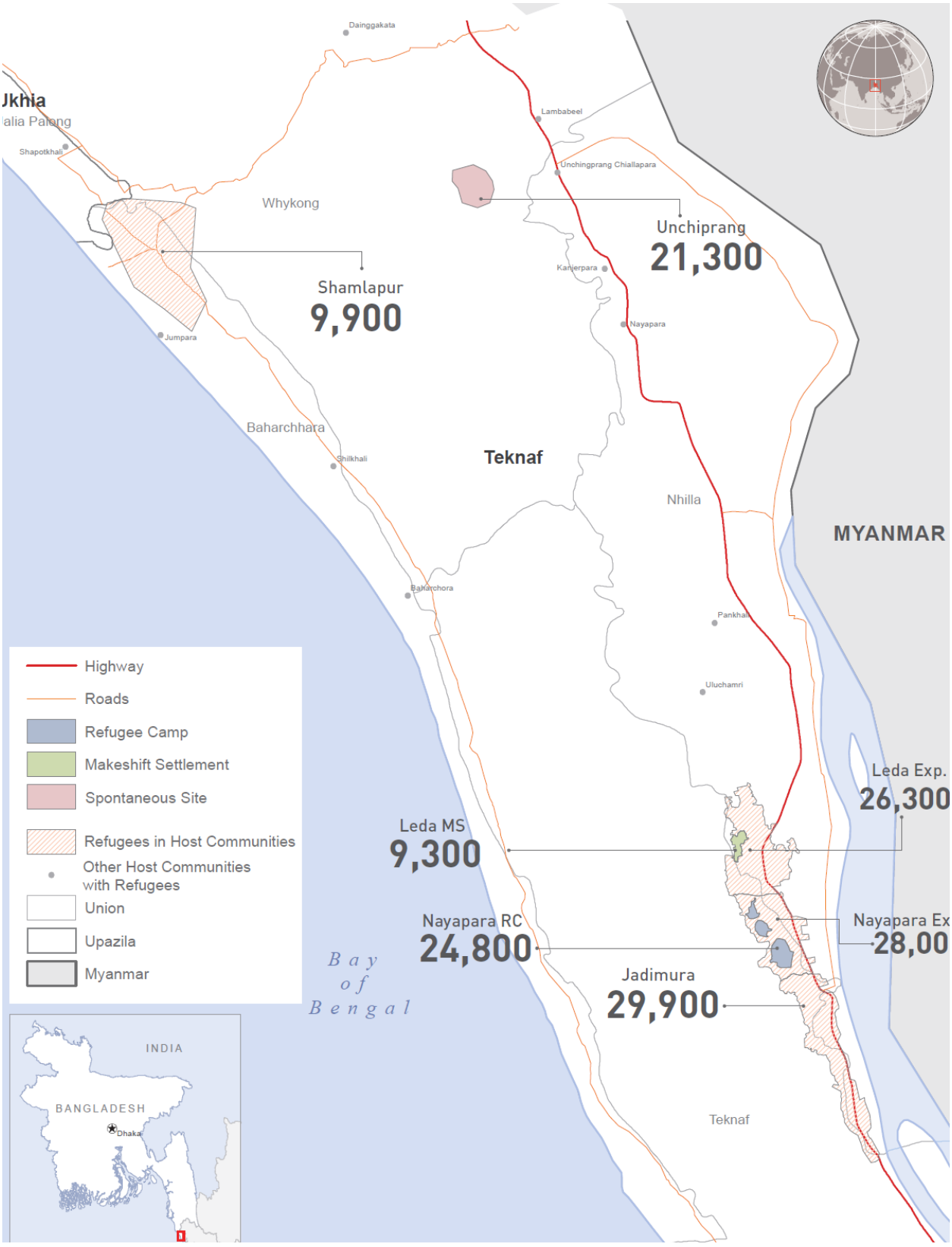
- 84% latrines are not sex-separated
- 91% WASH facilities do not have adequate lightning
- 5% individuals eating only rice and 2% eating only once a day
- 67% locations where children have access to the School feeding programme
- 5% locations where people have trouble accessing antenatal healthcare
- **67% locations where people have trouble accessing psychosocial support**

SS camp 10- with 35,200 individuals and 8,300 households:

- 99% Latrines are not sex-separated
- 100% WASH facilities do not have adequate lightning
- 8% locations where people lack cooking fuel
- 20% locations where children have access to the school feeding programme
- 22% locations where people have trouble accessing antenatal healthcare
- **86% locations where people have trouble accessing psychosocial support**

Leda camp- Leda A- with 10,300 individuals and 2,500 households:

- 100% Latrines are not sex-separated
- 100% WASH facilities do not have adequate lighting
- 5% Locations where people lack cooking fuel
- 68% locations where children have access to the school feeding programme
- **77% locations where people have trouble accessing psychosocial support**



Map 2- ISCG Feb/ 2018

Creation date: 26 February 2018 | Sources: ISCG, RRRC, Site Planning and Site Management Sector
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations

RESPONDENTS

229 Rohingya refugees in Cox's Bazar participated in focus group discussions, comprising 58 adults aged 30-55 years old (43% male and 57% female), 58 elderlies aged above 60 years old (50% male and 50% female), 53 youth aged 18-25 years old (42% male and 58% female) and 60 children aged 7-12 years old (58% male and 42% female).

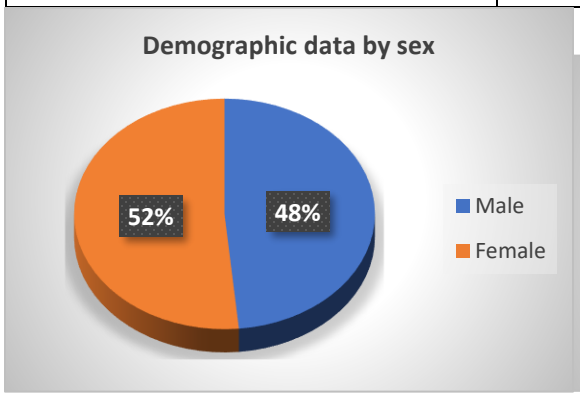
The participants were randomly selected but distributed among the blocks around the IOM health clinics.

40 key community leaders within the camp population participated in a focus group discussion, comprising of head mahji, mahji, side mahji, imam and teacher. Rohingya are organised according to a majhi system. A majhi is a traditional leader who is in charge of a block. One block typically consists of around 100 households There were 20 respondents in Leda, 10 respondents in Kutupalong and 10 respondents in SS zone.

T56 health workers were also part of focus group discussions, comprised of doctors, nurses and health promotors from IOM health clinics. There were 20 respondents in Kutupalong, 20 respondents in Leda and 16 respondents in SS zone.

Table 1- overall sample distribution

Group	Kutupalong		Leda		SS		Total
	M	F	M	F	M	F	
Affected population							
Elderly (60 years old above)	10	10	10	10	9	9	58
Adult (30-55 years old)	10	10	5	15	10	8	58
Youth (18-25 years old)	10	10	2	14	10	7	53
Children (7-12 years old)	15	5	10	10	10	10	60
Total	**45**	**35**	**27**	**49**	**39**	**34**	**229**
Community leader	**10**	**-**	**18**	**2**	**10**	**-**	**40**
Health worker	**12**	**8**	**10**	**10**	**6**	**10**	**58**



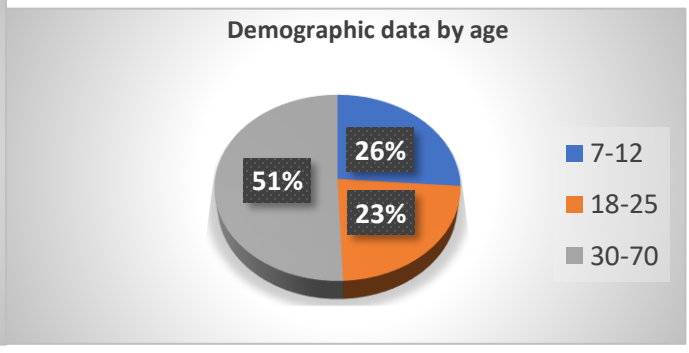


Figure 1 Gender distribution **Figure 2 Age distribution**

METHODOLOGY

The method used was a mixed one and included:

- Review and analysis of relevant bibliography
- Focus group discussions (FGD) both with key leaders and health professionals guided by a questionnaire
- Focus groups discussions (FGD) with refugees that were guided by a questionnaire

Focus Group Discussion (or FGD) as a qualitative research method was considered the most adapt for this study due to a combination of existing manpower and capacities, the difficulty to conduct a quantitatively reliable study vis a vis the impossibility to identify a representative sample, and the objectives of the study. GDs of one hour and a half each were conducted with a predetermined semi-structured interview led by a moderator. The interview was divided into 4 sections, with a total of 19 questions. The first section was aimed to explore the main problems affecting mental health and psychosocial wellbeing of refugees. The second section was aimed to explore their main coping mechanisms and resilience responses. The third section aimed to identify traditional idioms for distress and other emotional issues, and finally the last section explored the respondents' perceptions on availability and accessibility of MHPSS services.

There were 4 types of questionnaires to guide the focus groups discussions: 1- Child friendly version; 2- Adult version; 3- Key informant's version; 4- Health workers version (Annex 1, 2 ,3 and 4) .

Quantitative component:

The moderator presented several statements and participants were asked to evaluate their adherence to the statement in a scale from zero to four, where 0 (zero) was Never and 4 (four) was always. Due to low levels of literacy, the best method of collecting this data was through hand raising. Participants had to raise their hands with their answer (showing 0 to 4 with their fingers) all at the same time to the Group.

Interval scales from always to never (frequency of the situation/emotion stated in the statements) Two rating scales (Likert) were used:

Part A: A scale to estimate problems and needs with statements such as: how often do I feel… sad, tense, nervous, anxious, safe, grieving.

Part B: A scale to estimate resilient responses and coping mechanisms, with statements such as: How often… I laugh and smile, I have friends, I like being with my family, I am optimistic, I prefer being here…

Qualitative component

Focus groups discussions lasted one hour and a half each were conducted with a predetermined semi-structured interview led by a moderator. The questionnaire of the interview was divided into 4 sections, with a total of 19 questions: The first section included questions identifying main problems affecting mental health and psychosocial wellbeing of refugees; The second section included questions exploring main coping mechanisms and resilience responses; The third section included questions to understand traditional idioms for distress and other emotional issues; And the last section explores perceptions on availability and accessibility of MHPSS services

Study restrictions

- The difficulty to conduct a quantitatively reliable study vis a vis
- The impossibility to identify a representative sample, and the objectives of the study.
- It must be noted that results of this exercise are indicative only, since the results can be biased by the fact that responses had to be given in front of a group,
- these findings are not intended to be conclusive neither pretend to be a generalization of mental health and psychosocial concerns or issues of the Rohingya community.
- Findings are indicative of this sample who participate in the FGD a total of 300 people.
- Results as indicators and informing the developing of future interventions, but not as generalisations on mental health and psychosocial wellbeing, as it is always important to consider singularity and complexity of human beings.

Analysis of data

All the scores from 0 to 4 were recorded in an excel sheet. When participants given their answer, it was counted how many participants were adhere to each frequency for each single statement and then their answers were recorded in the excel sheet. Calculations were made individually for each single statement and for each frequency. The data collected in focus groups was analysed qualitatively, while semantic groupings were computed in Excel, analysed descriptively and mapped through the simplified version of Papadopoulus' Grid (table 2).

Table 2- Trauma Grid

Levels	**Negative responses**			**Positive responses**	
	Injury Wound			Resilience	Adversity activated development
	Psychiatric disorders	Distressful psychological reactions	Ordinary Human Suffering		
Individual					
Family					
Community					
Society and culture					

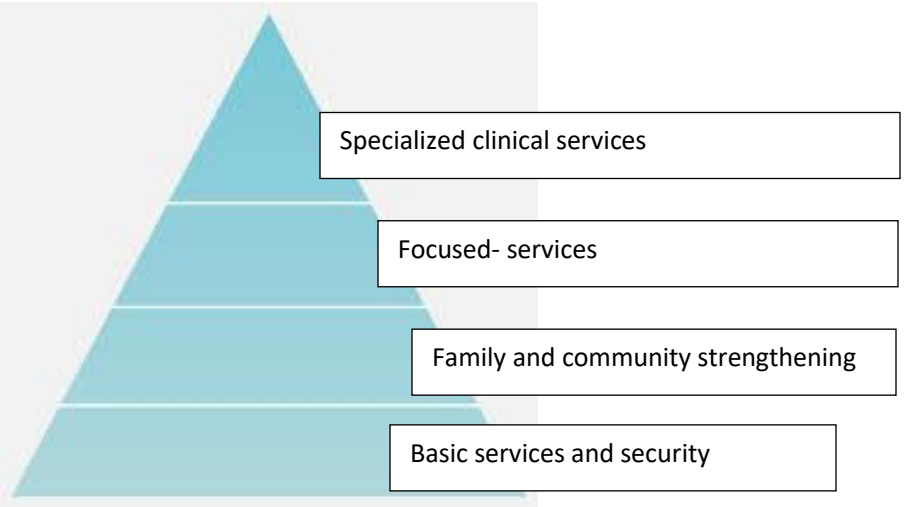
KEY FINDINGS

The analysis of the main findings is going to be divided into four sections, according to the protocol used: **1- Main MHPSS problems**; 2- **Main coping mechanisms and resilient responses**; 3- **Traditional idioms**; 4. **Perceptions on availability of MHPSS services**. Each section addresses also main needs categorised in different levels: individual, family and community level and differentiates three types of responses – negative psychological responses, resilient responses and adversity activated developments.

The Grid is helpful to consider the totality whilst, at the same time, provides a framework to differentiate in a more specific way the wide range of responses to adversity. In this sense, it is avoiding unhelpful generalisations, overall diagnoses and polarisations. According to Papadopoulus (2007), an individual is not just 'traumatised' or 'resilient' in an undifferentiated way – each person, apart from experiencing the negative effects of the devastating events that made him/her a refugee or forced displace, also retains some existing strengths (Resilience) as well as acquires new positive qualities (AAD). This grid is also a reminder that individual pathology is just a small portion in relation to the wider range of other type of responses to adversity. Being aware of this totality, provide a better understanding to identify the effects of trauma and avoiding lineal explanations, oversimplification approach to human suffering.

The pyramids of MHPSS service, as identified in the relevant IASC Guidelines (Fig 3) provided a framework to organize key programmatic elements and actions to be taken.

The pyramid of psychosocial intervention (Fig 3)



I. MHPSS Needs and main problems- Psychological reactions

1.2 INDIVIDUAL NEGATIVE RESPONSES RESPORTED AS BEING ALWAYS PRESENT

In this section, participants were asked to answer to how often they feel the following feelings, in the interval scale from never (0)- little (1) – sometimes (2), (3) often and (4) always.

In this report, it is highlighted just the higher percentage of responses for the frequency always, as this study is aiming to identify general and main mental health and psychosocial needs as well as main coping mechanisms.

Table 3- Overall sample distribution

	Adult	%	Elderly	%	Youth	%	Children	%	Total	%
Total respondent	**58**		**58**		**56**		**60**			
Sad	43	74	9	16	32	57	23	38	107	47
Tense	37	64	9	16	0		21	35	67	29
Nervous	28	48	0		0		19	32	47	21
Troublesome	17	29	0		0		9	15	26	11
Grieving	18	31	18	31	6	11	20	33	62	27
Fearful	3	5	0		2	4	8	13	13	6
Safe	38	66	18	31	6	11	17	28	79	34

- 47% manifested to be sad always. (38% children74% adults and 32% youth)
- 29% of participants reported to feel tense always. (64% adults, 35% children, 16% elderly)
- 21% felt nervous always. (32% children and 48% adults)
- 34% felt safe in the camp and by living in Bangladesh always. (68% adults, 28% children, 11% youth).
- 27% of participants manifested grief always for their lost family members and their previous life. (63% adults, 23% children, 45% elderly)

Psychological distress indicators

These indicators were captured by qualitative component during the FGD guided by the qualitative questionnaire (Annex 1).

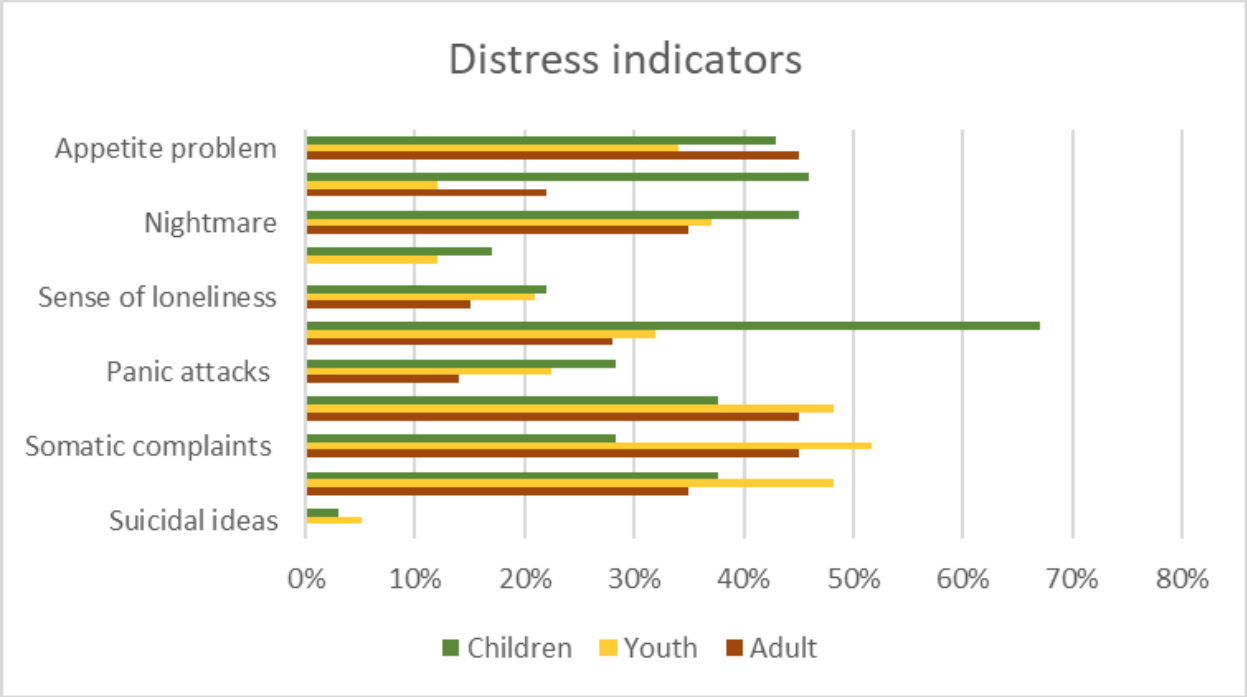


Figure 2- Main distress indicators

- 45% of the total participants reported experiencing some distress indicators and other negative feelings ,mainly among children and youth.

- 38% of children who participated in the FGD reported sleeping problems since they were displaced, due to bad memories of the events that occurred. Some children voiced their fears to fall asleep because memories of what happened will appear. 48% of youth reported sleeping problems, and they attributed these problems to the current poor conditions they are living in. Youth expressed how stressful the current situation in the camp is, that there are opportunities for education, livelihood or recreational activities: …" we feel like living in a cage" (Youth, 21 years old)
- 21% of participants among children and youth reported feeling anxious about the future and the uncertainty of what is going to happen to them. 38% of children expressed that the current situation, including food shortage, not knowing where and how their relatives who were left behind are, among other factors make them feel anxious and sometimes unable to concentrate enough at school: "I just want to pray and not to talk to anyone" (Girl, 8 years old)
- 20% of participants reported some sort of somatic complaint, headaches, sore muscles and backpain. 52% of the youth respondents expressed one or more indicators of physical uneasiness, specially headaches. In the case of children, 28% reported health and somatic issues, such as backpain, stomach ache and sore muscles.

- It is important to highlight the 4% of youth respondents reported suicidal ideas. This is quite significant taking into consideration that those participants also reported their lack of educational and employment opportunities and a sense of being held in captivity in the camp.

Table 4- Individual negative responses

Levels	Negative responses Psychological distress indicators
Individual	Feelings • Sad (47%) • Tense (29%) • Grieving (27%) • Worried (21%) • Troublesome (11%) • Fearful (6%) Factors • Lack of basic need/ social amenities of life (58%) • Loss of family member (51%) • Previous life-threatening experience (40%) • National identity crisis (40%) • Poor health condition (36%) • Lack of freedom to move outside the camp area (30%) • Safety and protection (18%)

A sense of being sad most of the time…

When respondents were asked to identify what was their main feeling living in the camp:

- 47% of respondents expressed negative feeling such as being sad most of the time, nevertheless 27% expressed gratefulness for being in Bangladesh, as they could resume their religious life and their lives are not continuously at risk.

Grieving due to loss of family member was highlighted by some respondents, particularly children. Furthermore, children respondents reported that they were exposed to horrific events in their country of origin. Some children mentioned a feeling of guilt or remorse as they said they could not do anything to help her love ones or “They were buried not in religious way. They make a big hole and buried them together”. These experiences have created several psychological reactions, such as fears, nightmares, flashback memories, sleeping problems, loss of interest in playing, appetite problems and sense of loneliness. Sadness, feeling tense and-or nervous are dominant anytime the children remember these events.

We feel in captivity…

The most common problems and factors that are affecting psychosocial wellbeing and mental health are:

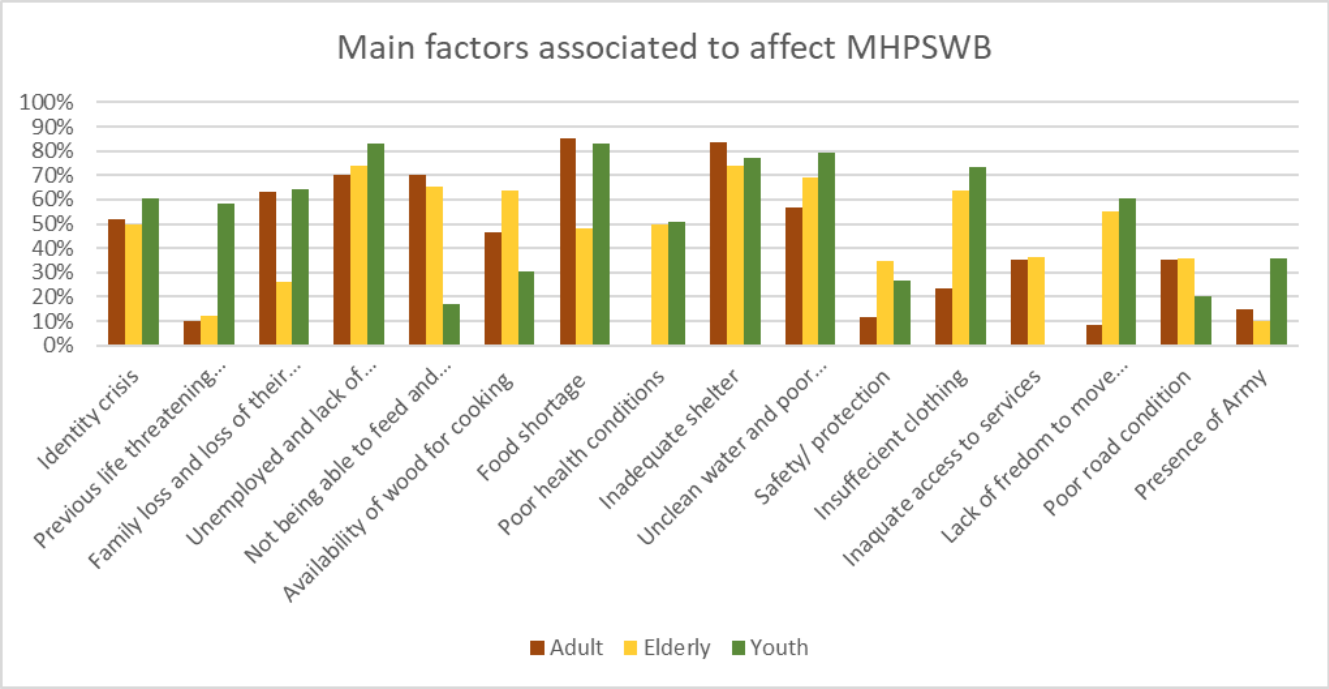


Figure 3 - Main factors associated to affect MHPS

The above figure shows main factors associated by participants that are affecting their mental health and psychosocial wellbeing. The figure is distributed in targeted groups and percentage of participants who mentioned these factors as the most important ones:

- Food shortage; respondents reported a shortage of relief, which lacked complimentary food (vegetable, meat etc). They also mentioned that the schedule of relief distribution is not frequent enough. This situation provokes sad feelings for most of respondents, including children. As mentioned, “I’m sad because I used to have food three times a day, but since the relief was late, I eat twice a day”. In addition, they lack cooking fuel. To address the issue, some adult respondents mentioned that they tried many ways to deal with the challenges, for instance selling their Non-Food Items (NFI) to get money that will be used to buy complimentary foods, such as meat and vegetables. Additionally, some individuals try to inaccurately claim their nationality as Bangladeshi to leave the camp to work. However, this course of action is thwarted by recognition by the Bangladeshi army which results in lack of freedom to move outside the camp.

- Inadequate shelter, poor lights, poor WASH facilities and insufficient clothing. Were also mentioned. Inadequateness of shelter was qualified in the lack of personal space, inadequate lights, tarpaulin, lack of floor and sturdiness. Most of female youth mentioned that the shelter made of tarpaulin could not protect them properly. As mentioned, “Someone could easily tear my shelter and I’m scared of it”. Other adult respondents mentioned, “When the sewage next to

us was leaking, the water flowed to my shelter and entire place were wet and muddy. We could not sit or sleep". Current shelter conditions and the upcoming monsoon provoke worries for the respondents.

- 58% of the respondents mentioned lack of basic needs
  40% of respondents mentioned how the fact of not being recognised as citizens and being denied access to their country services, and their current uncertain situation about their citizen and political status in Bangladesh, is causing them anxiety, stress and fear.

1.3 FAMILY NEGATIVE RESPONSES AS BEING ALWAYS PRESENT

At the level of the family suffering, when respondents were asked to identify feelings and factors affecting the psychosocial wellbeing in the family, were they mentioned similar aspects of the ones they mentioned on an individual level, but often adding new perspectives that could help future programming.

Level	Negative responses
	Injury Wound
Family	Feelings • Anxiety (25 %) • Uncertainty of what would happen to them and to the ones they left behind (64%) • Sadness (74%) Factors • Safety and protection (15%) • Unemployed/ lack of opportunity (23%) • Loss of family and property (25%) • Lack of freedom to move outside the camp area (25%) • Poor health condition (45%) • Family separation (51%) • Basic need fulfilment (52%) • Previous life-threatening experience (56%)

Worried about how to provide food to my family…

One of the main concerns and problems was again food shortage.

Rice is the staple food grain of Arakan- Rakhine. The diet of the Rohingya is simple: rice, fish, vegetables and chillies; meat was taken on occasions. The majority of Rohingyas eat dry fish with either fresh vegetables or potatoes. Indeed, cooking rice is a very important family gathering that has been restricted due to the lack of cooking fuel, food shortage and overcrowded conditions within the shelters.

An adult respondent mentioned, "I'm sad most of the time. Every day, I think about what my family would eat, even today I don't know what to eat for lunch". Besides, less complimentary food was another stressor that made the family feel uneasy since they worried about the nutrition of their children. Nevertheless, in a different group, some health worker said that the food supplies were supposed to be enough for the family but since beneficiaries sell their supply to get other items, this creates food shortage in the family.

Other main factors affecting their mental health and psychosocial wellbeing were:

- Basic need fulfilment constraints
- Unemployment and lack of freedom to move outside the camp area
- Sense of loss
- Previous life-threatening experience
- safety and protection and poor health condition.

Another distress factor that were mentioned by most of target groups, health workers and key informants together was **overcrowding**.

Most of health workers mentioned that family planning is the biggest challenge since most Rohyinga refuse to follow family planning. Based on their data, most of Rohingya refugee family have more than 6 children. Several reasons were given for this issue: 1) the belief that they family planning is a sin and forbidden in religion; 2) pregnancy is a "lifesaving" state and a protector factor as women perceived the only time when they are not badly treated or hit by their husbands; 3) pregnancy could bring more privilege for family in the current situation, such as more relief aids. Health workers added that too many children in the family affected the quality of parenting, since the parent could not look after them physically and psychologically in a proper way.

Overcrowding and family sizes act as propellant for contagious diseases, compounded by a lack of health awareness in the family. All groups of respondents confirmed that disease can spread quickly within a family.

Cultural segmentation practices of Rohingya include endogamy, that reinforces ties of common descent and gives a perception of not belonging to other groups. One girl respondents mentioned: "Now, I am alone, no family members… my life has ended as I will never get married to any non-Rohingya man".

Finally, it is important to highlight that most respondents perceived dramatic changes in their family structure due to the horrific events and the camp conditions. In some cases, women as per religious barriers or due to their head households' situation, they have restrictions to leave their homes and this is difficult to get access to health services, or food relief, for instance or leave other kids unattended.

Unaccompanied children in the case of this study represented 8% of the sample, in their case, they were cared by some relatives or in some cases no adults in their households.

1.3 COMMUNITY RESPONSES

Level	Negative responses
	Injury Wound
Community	Feelings • Generalised fear (15%) • Camp conditions (25 %) • Worried and anxiety (27%) Factors • Not being recognized as citizens (40%) • Economic constraints to celebrate some of their rituals (23%) • Travel restriction (20%) • Public facility (road and latrine (18%)

When asked about the main issues affecting the community at large, the respondents highlighted substantially different items than the ones mentioned at the individual and family levels.

At the community level, main causes of distress are associated to travel restrictions, and the discriminatory refusal to recognise them as citizens that are preventing them to be entitled of higher education, health care and job opportunities. These factors are affecting a high proportion of the youth population, who mentioned in the FGD how frustrated they are because of the restriction to attend school beyond primary level and the impossibility to have a formal job. In the FGD, participants mentioned how disturbing is the fact of being seen as outsiders everywhere, not only in relation to the more practical implications but also for the effects on their self-esteem and sense of identity.

In addition, 80% of Rohyngya in Myanmar were earning their livelihoods in agriculture or pasturing. Other traditional occupations were trade in food, commerce, transport by water and by road, carpentry, fishing, and tobacco and salt manufacturing. Many of these occupations, particularly agriculture, fishing and pasturing, are highly affected by the displacement and this causes of psychosocial uneasiness.

Among the factors that contribute to negative feelings at community level in the current situation, most respondents mentioned lack of lighting, latrines, and proper roads, particularly for vulnerable group such as women, children and elderly. Most of the female respondents mentioned that they have difficulty

accessing latrines at night. Furthermore, there are a limited number of latrines when compared with the number of users – this was an issue for them, as they mentioned one latrine can be used by as many as 10 families. Long queues can provoke embarrassment as well as sadness for them. Latrine conditions as mentioned in the NPM assessment survey are not sex- separated for instance in almost all locations where participants were living.

The hilly road access hinders elderly commuting to pray at the mosque. Yet, praying together at the mosque was mentioned by most respondents as a main resilience factor at the community level. One of FGD the number of prayers at mosque in each block was considered an indicator of resilience and wellbeing.. In this context, the meaning of praying is not only personal faith, but lies also in the collective spirit to worship to be able to support each other socially and emotionally.

All Rohingyas profess Islam, and they are generally strict followers of Islamic traditions. In comparison to Myanmar, in Bangladesh they can go to Mosque and pray but due to economical restrictions, they cannot celebrate other holy festivities as part of their culture and religious life.

Most of the respondents in this part of the interview mentioned their collective expectation to be reintegrated in their country. This was not only caused by poor living condition in the camp, but it is more related to the sense of belonging to a country, a territory and a community.

The respondents' expectation to go back their country of origin was however ambivalent. Most respondents showed a strong desire to return to Myanmar but in the same time they realized they lost family members and all their properties. In addition, most of them still carry a vivid memory of the violence they were subject to. Therefore, the desire and intention to return is also linked with narratives and expectations of land restitution and of full safety.

Relief and humanitarian aid is distributed respecting their traditional organization and cultural rules, which has helped them to preserve the socio-political structure as an ethnic group: prominent authorities included: mullahs (Quran scholars who often led mosques), mulvis (heads of the madrassas) and elders are their public administration committees. The structure to provide and organise the humanitarian relief is seen as a way to respect their socio-cultural structure.

II. RESILIENT RESPONSES AND COPING MECHANISMS

2.1 INDIVIDUAL RESPONSES

Table 5- Positive responses at individual level

Positive responses	
Resilience	**Adversity-activated development**
• A degree of reaching out (35%) • Ability to adapt themselves (40%) • Expressing their sadness to the closest ones (45%) • Religious activity (67%)	• Informal association to peer support groups, such as women and widows groups

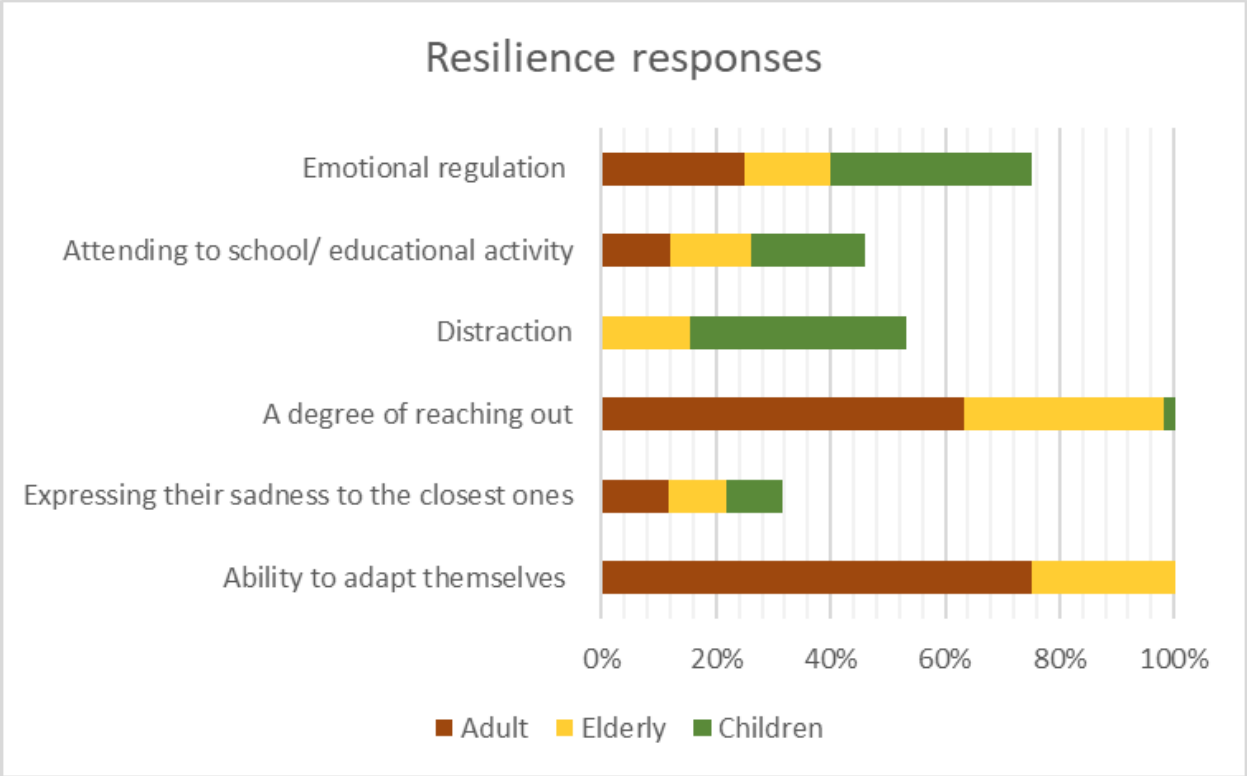


Figure 4- Main resilient responses at individual level

- When children respondents were asked about what they used to do to feel better, most of them mentioned crying and talking to their parents. A few children instead consciously decide not to

share negative feelings within the family, they mentioned “I didn’t share because my mom will be sad and cry”. They tend to repress the feelings and use other coping mechanisms, for instance playing with friends or taking a long walk to find fire-wood and any other menial activity that can distract them from feeling sad.

- When the respondents were asked about how they deal with negative situations, most of them mentioned praying. Moreover they see themselves as individuals with an ability to adapt “we survive every day, we accept what happened and we just survive” (Man 68 years old) t. Religious activity is the highest resilience factor for Rohingya refugees (67%). They believe that God is the only saviour and praying could relieve them from their uneasiness. Other resilience factors are family relationship (45%) and adaptation skill to survive (40%).
- It was also found a high adjustment and, in some cases, emotional expressivity to their love ones, the strong family relationships allow in many cases to deal with the distress and uneasiness. 45% of respondents mentioned the family as the relationship that allow them to cope with the current situation and a safe space to express their emotions.

2.2 FAMILY RESPONSES

Table 6- Main positive responses at family level

Positive	
Resilience	**Adversity-activated development**
• Encouraging each other by using proverbs from the Koran (15%) • Child-parent bonding (23) • Cooking rice together (32%) • Family support (45%) • Praying time (67%)	• Supporting families with children, especially women groups (12%)

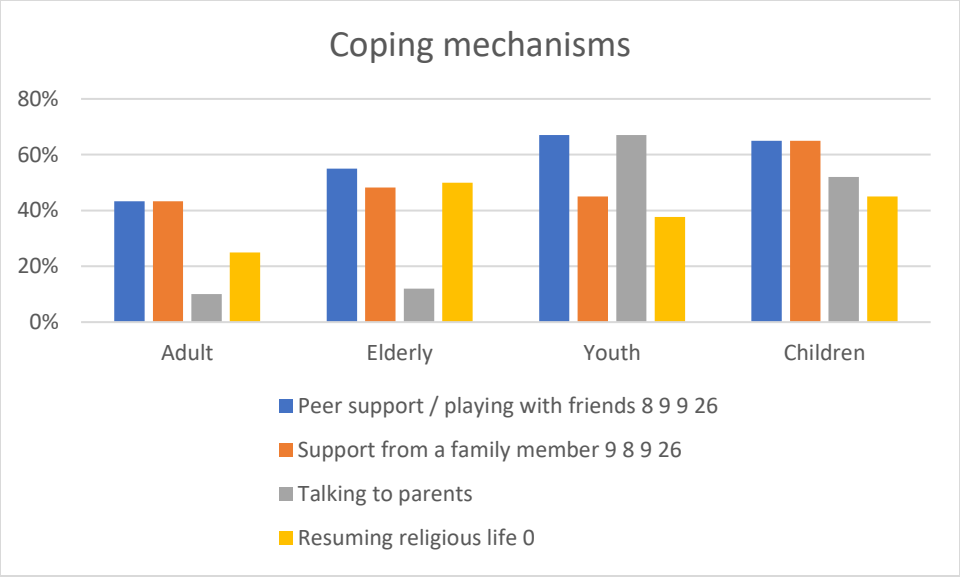


Figure 5- Main coping mechanisms at family level

Before the displacement emergency, Rohingya community were banned to practice their culture and religious life, and currently in Bangladesh they were able to resume their religious life. For all the targeted groups, religion is a coping mechanism that act as stress moderator and buffer the effects of exposure to violence. The main coping mechanisms are community and group related activities, showing how Rohingya community is a strong gregarious society that in their own words: "we can survive so many years of abuses because we remain together after all"

Parenting and family bonding

Even though the health worker group mentioned that parenting quality is reduced due to the number of children, based on the finding in the children group, 45% of children participants reached their parents as their emotional support when they have uneasiness. Parent-child bond is perceived as a resilience factor at the family level that would be strengthened in the proposed intervention.

When the respondents were asked on how they, as a family, cope with their negative feelings, most participants answered, 'praying and getting support from the family'. In the Rohingya refugee context, the bond among family members is quite strong to affect each other. As like negative feeling resonated to one another, they cope with the challenge and deal with negative feelings as a unit. There was no ritual that the respondents mentioned as a coping mechanism, yet comforting, talking and spending time with family were relieving activity for them. However, they use the Koran and proverbs as a way of comforting each other and provide a sense of calmness and inner peace.

2.3 Community level

Table 7- Main positive responses at community level

Positive	
Resilience	**Adversity-activated development**
• Trade in food-stuff (15%) • Keeping traditional games and plays (22%) • Social network (32%) • Quality of friendship (36%)	• Proverbs telling in groups (12%) • Advocacy capacity to solve daily challenges (23%) • Communication skills to disseminate key messages (25%)

Regarding, coping mechanism to relieve uneasiness, most respondents answered that they get support from neighbours, community leaders and spiritual leaders.

In the refugee context, there are two main roles in the community leadership: Mahji and Imam. A Mahji is the community leader who leads community mobilization and solves disputes. 1 Mahji covers 100 families. The Mahji is assisted by an assistant that they call 'side mahji' and a volunteer. Meanwhile, the Imam is the one who gives advice for the ones who seek religious guidance and support. The two key leaders collaborate well in the community.

Key informants in the FGD mentioned that community self-help was shown in some of the camp by how they organize and solve the problem independently. The ways that they took to discuss and solve the issues were community meeting and religious gathering. Key informants added that once the Mahji and Imam decided, community members would comply with their decision. When they were asked to identify what could be done to strengthen the community, most respondent answered 'having a community meeting, facilitate a community gathering and a religious gathering.

A sense of feeling safe

Youth and children described how their sense of safe has also allowed them to resume one of the most important community activities which is cultural and religious life. Adults and elderly manifested how important is to feel that their lives are not threatening in the camps "at least now we can say we are Muslims"

Children are able to attend schools and this activity in itself facilitate their process of recovery, however despite the lack of higher education opportunities what is important for Youth groups is their willingness to study, most of the youth manifested their abilities to defend others and how they could pursue subjects as Law and international affairs

Restoring some occupational activities

The social capital defined as "features of social life—networks, norms, and trust—that enable participants to act together more effectively to pursue shared objectives" (Putnam, 1995; Pelling and High, 2005) was an important factor in community coping capacity to climate stresses. In the FGD, and in the field observation some of the participants have been able to trade in food-stuffs, and, they are shop-keepers. This is an important feature that would need to strengthen in the view of MHPSS community activities, vocational training and occupational activities.

Before the emergency, as community conflicts were solved with the mediation of a third party from the socio-political structure in each village, and now some of the families reach elders/leaders/madjis/peers to receive support.

III. PSYCHOSOCIAL IDIOMS

In this section participants were asked to provide description in Rogingya language the meaning of each of the psychosocial term. In this regard, it is important to highlight how the description of most of the psychosocial terms were related to their sense of loss and national identity crisis. Most of the participants manifested that this feeling of being uneasy "Dukh" is generalised in the community.

Psychosocial term	Local term	Description
Sadness	Dukh/ dukhita	30 participants stated, related with the lack of basic need fulfilment for example limited health facility, lack of education for children, housing (small house, not getting bamboo to build a house, suffering cold due to many unshielded hole) and food relief distribution by WFP (distance, system and approach of the humanitarian worker). • 3 participants stated it is related with lack of employment for youth and adult.
	Arar beshi dukkot	• Anxious and feeling insecure due to lack of security around their living place (6 participants)
Depression	Endilladukh arnai	• The feeling of having nothing in life that can't be tolerated anymore, such as leaving all the belonging and house in Myanmar and now having a small house, suffering from cold (10 participant).
	Pereshani	• Unbearable feeling due to not staying in one's country, could not move freely and no money (10 participant).
	Hotash	• The feeling when the refugee could not be guarding their family (4 male participants).
Fearful	Dhor/ dhor Lagette	• The feeling when the Bangladeshi send the refugee back to Myanmar and they got killed by Myanmar Army (10 participant) • Could not get nationality status (10 participant) • The feeling when the refugee far away from the family (1 participant) • The feeling when could not move in the night due to no lighting around (6 participants) • The feeling when Myanmar army do the oppression, get torture that finally decided to leave by boat (2 participants)
Anxiety/ worried	Pereshan/ shinta	The feeling when the refugee has not get Myanmar citizenship and they must return back.
	Bhabi takidde	• The feeling when one of the family is going to have something outside and he is not coming back home yet (1 participant).

		• The feeling when the refugee has been staying in the camp for 18 years, after previously got oppression for 42 years and now worried about the future (1 participant)
Happiness	Kushi	• The positive feeling after getting aid/help from many NGOs, could pray without any fear, and stay safe in current place (10 participant). • The feeling when refugee could go back to Myanmar (20 participant)
Hope	Asha	The positive feeling of getting citizenship in Myanmar, justice after getting torture from Myanmar army and getting the property back by the help of UN or other external party (30 participant)
Hopeless	Hono assanai	The feeling when Myanmar army push them back to Bangladesh several times while they could not stay safe in Myanmar (20 participant)
	Arar no paiyum	The feeling when the Myanmar Government would not repatriate the Rohingya refugee (10 participant)
Attached	Khunor tan	The feeling of brotherhood as a Muslim (10 participant).
	Poati thaka	The feeling of getting protection from their social support when Myanmar Government or local people use the weapon to torture them (10 participant)
Belonging	Maal/ acis Gushi	Materials like kitchen utensils (20 participant) Having connection/Family relation (10 participant)
Isolation	Aleg oigiyee / Bagghore	Being separate / the sad feeling due to their family was killed or leave the family (20 participant)
	Sirah	Make someone to be alone (10 participant)
Loneliness	Khaliga	The feeling of not living with relatives/ family (20 participant)
	Ekzon	The feeling of being left by the community (10 participant)
Safe	Shanti/ edminan	The positive feeling when children, family and property are secure, not worried of being arrested by army and living with the feeling of not being killed (30 participant)
Lost	Azzi giye Harai giye	If they lost material goods (30 participant) Lost family (10 participant)
Trouble maker	Harap manush	The person who initiate fight and problem among them

IV. Perceptions on availability of MHPSS services

The MHPSS mapping services has shown the following activities conducting by MHPSS partners that are actively working in the MHPSS WG, mainly ACF, BRAC, MSF and IOM:

Table 8- Mapping of existing services - MHPSS task force Cox's Bazar

1. Dissemination of information to the community	1.1 Awareness raising on Mental Health and Psychosocial Support (e.g. messages on positive coping or mental health services and psychosocial supports)
2. Community mobilisation	2.1 Support for emergency relief that is initiated by the community 2.2 Support for communal spaces or meetings to discuss
3. Safe spaces	3.1 Child friendly spaces 3.2 Women and girl friendly spaces 3.3 Baby Friendly spaces 3.4 Age friendly spaces (elderly)
4. Psychosocial Support	4.1 Basic psychosocial support 4.2 Psychological First Aid 4.3 Stress management 4.4 Individual Psychoeducation 4.5 Group psychoeducation 4.6 Structured group activities (e.g. family supports/mother's groups/youth group) 4.7 Psychosocial support in education
5. Counselling	5.1 Individual counselling 5.2 Group counselling

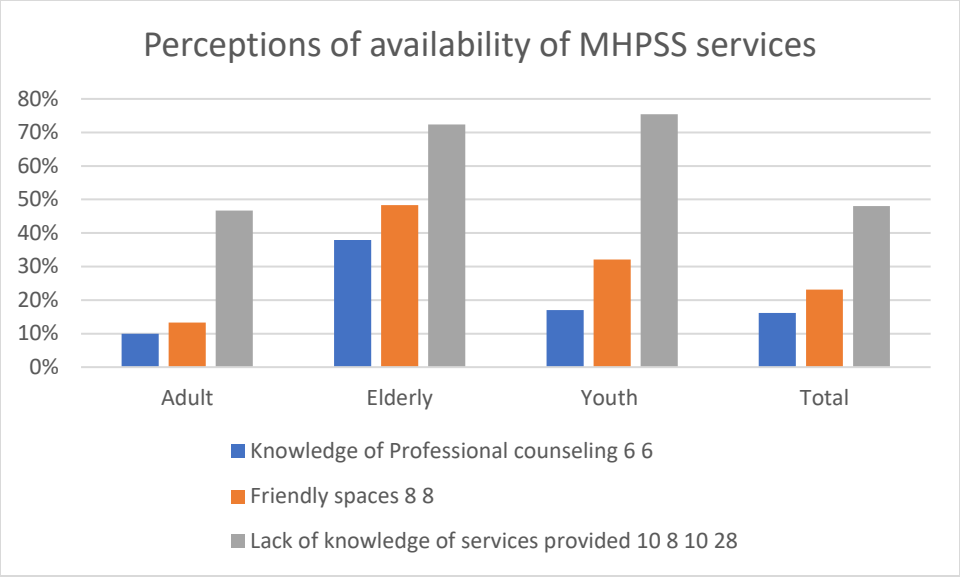
6. Psychotherapy	6.1 Individual psychotherapy 6.2 Group psychotherapy 6.3 Case management for patients under psychiatric medication prescription (incl. Counselling or psychotherapy)
7. Clinical management of mental disorders	7.1 Non-pharmacological management of mental disorders 7.2 Pharmacological management of mental disorders 7.3 Inpatient mental health care
8. Advocacy	8.1 Linkages with government 8.2 Linkages with donors 8.3 Linkages with sector and coordination

These activities are conducted in most of the main camp sites, however the outreach capacity is still very limited and mainly focussed on levels 2 and 3 of the Pyramid of the general MHPSS response:

- Counselling
- Basic psychosocial support
- Safe spaces

According to the NPM people reported to have a difficult access to psychosocial support in the three camp sites where this assessment was conducted:

- In kutupalong 67% mentioned have trouble accessing psychosocial support, 86% in SS and 77% in Leda.



In the FGD, when they were asked for the availability of existing MHPSS services, 48% respondents mentioned they didn't have any idea about mental health and psychosocial services in the camp particularly related to stress relieving activity. The only service that they mentioned was child friendly space, but this service is identified as a regular educational activity not as a psychosocial support space.

The offer of specialised mental health and psychosocial services in Cox's bazar is quite limited in scope and when services exist, those are confined to psychopharmacological treatments. In this regard, adequate training is required to provide key indicators and a comprehensive way to assess mental health and psychosocial conditions.

RECOMMENDATIONS

Based on the results of the assessment, there are several areas that need to be strengthened to maintain mental health and psychosocial wellbeing within the Rohingya and host community. The actions below are mapped in the pyramid of psychosocial intervention in emergency as identified in the relevant IASC guidelines.

Level of intervention	Objectives of the study	Findings: factors associated to affect MHPSS and feelings	Recommendations	Activities	Sector
1- **Basic services and security**- "The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs. documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in safe, dignified, socio-culturally appropriate ways that promote mental health and psychosocial well-being" IASC	**Identify MHPSS needs**	Factors: • Food shortage as a factor to affect their MHPWB (85% of adults, 83% children) • Lack of complementary food (38% of children) • Lack cooking fuel (48% of respondents mentioned Distress indicator: • Feeling of sadness (74% of respondents)	• Mainstreaming psychosocial approach in the way it is distributed food relief and registration to get access to food aid • Identify large families and children below 8 years old, and households with women heading	• Food distribution improvement at the distribution points • Family outreach through Madjis and other key leaders • Advocacy to strengthen the provision of sufficient food items and Non-food Items (NFI)	Nutrition Food distribution NFI
		Factors • Inadequate shelter/overcrowding and no adequate lighting (83% adults, 74% elderly, 77% children and 74% Youth) • Unclean water and poor sanitation conditions (79% of total respondents)	• Integrate cultural and family needs into the organization of shelters	• Advocacy to improve quality of health access • Advocacy to strengthen adequate shelter • Advocacy for hygiene kit provision and additional latrine provision in a safe and appropriate manner	Shelter Site management Site development WASH
		Factors	• Mainstreaming psychosocial approach	Advocacy to improve outreach capacity	Health sector

		• Poor health conditions (adult 75%, 82% elderly and 42% children) Distress indicators • Somatic complaints (20% total of respondents) • Sleeping problems (44% total respondents, 48% youth, 47% children)	into the health response		
		Factors • Lack moving freely outside de camp (60% of youth; 43% of children) • Lack of employment opportunities (74% of adults and 83% of Youth) • Identity crisis (73% of total respondents Distress indicators • Anxiety (45% of total respondents)	• Increase participation and job opportunities to the Youth and head households	Advocacy to facilitate access to job opportunities	Protection sector
	Explore coping mechanisms and resilient responses	• Adaption skill to survive (40% of respondents)	• Increase participation of other members of the community (apart from Madjis) teachers, youth to outreach and solve basic needs of the most unreachable families and households	• Incorporate in the key critical moments of the humanitarian response (designing, implementing and evaluating) key community members (apart from Madjis)	Site management Shelter Education WASH

2. **Family and community level**: "the emergency response for a smaller number of people who can maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports" IASC	**Identify MHPSS needs**	Factors • Unemployment and lack of occupation (83% of adults, 78% of youth) • Family separation (51% total of respondents) • Camp conditions (35% of total respondents) Feelings • Uncertainty of what would happen to family members left behind (64% of total respondents • Grieving (76% of total respondents) • Worried (53% of total respondents)	• Actions to avoid family separation in relocation activities • Increase community participation in the improvement of camp conditions • Engaging youth into vocational and livelihood activities to activate their motivations towards community development. • Enhancing parental skills to allow the new family structure to deal and cope with the current situations	• Tracing and reunification actions • Assisted mourning and communal healing ceremonies and religious group activities • Organize group sport/games and recreational activities for children and youth • Organize structured activities for children • Non- formal and formal educational activities • Livelihood training activities • Supportive parenting programmes and establishment of women and youth groups.	Protection sector (Children and Youth) Shelter Education

	Explore coping mechanisms and resilient responses	• Trading in food stuff (25% of total respondents) • Peer support and playing good friends (54% of children) peer support (45% of youth) • Family support (56% of total respondents) • Praying and resuming religious life (64% of total respondents) • A degree of reaching out (64% of total respondents)	• Strengthening community reaching out skills through mass communication actions • Strengthening community and group dynamics to improve and transform healthy behaviours • Transform the way of understanding health response to individuals towards a more family, systemic approach	• Include members of the community into the rapid response teams for the emergency preparedness • Revise the key messages for awareness campaigns	• CwC • Health sector
3. **Focused non-clinical interventions**: supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (IASC)	**Identify MHPSS needs**	Factors: • Family loss (64% of total respondents Distress indicator • Flashbacks of the horrified events (45% of children; 56% of adults) • Grieving (65% of adults; 42% of children) Perception of availability of services • No information about MHPSS activities (48% of total respondents)	• Interventions for those targeted groups who exhibit grieving symptoms and distress indicators. • Identify and engage with selected universities with studies in mental health and psychosocial support to establish partnerships with the aim to encourage a knowledge exchange on programming and specific trainings that address main MHPSS concerns and the needs of the Rohingya refugees in Bangladesh • Dissemination of pathways and minimum packages on MHPSS	• Basic psychosocial support training to doctors and nurses • PFA training and do not harm approach • Developing a training and supervision programme for capacity building in MHPSS	Health sector MHPSS WG

	Explore coping mechanisms and resilient responses	• Emotional regulation (45% of total respondents) • Strong family bonding (54% of total respondents)	• helping to promote parenting skills, encouraging active family bonding and serving as a valuable community reference point. • Establishment of a buddy system within the community	• Train supervise workers, health promoters in promoting emotional regulation skills already present in the community • Training of volunteers on counselling skills • Group lay counselling sessions	MHPSS WG
4. Level: **Specialised services**: support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning" IASC	Identify MHPSS needs	• Death ideas (4% of youth) • Panic attacks (8% of adults) • Nightmares (24% of children)	• Psychotherapeutic interventions will require an approach that balances, (a)strengthening the availability and capacity of specialists to train and supervise and (b) shifting to the delivery of psychotherapy by non-specialists. • The strengthening of evidence for managing these conditions will require collaborative efforts by academia and practitioners in a manner that is mindful of local sociocultural and health system realities in Cox's Bazar.	• Qualifying the existence services with specialized training with techniques that have structured protocols and easy to supervise their impact efficacy • Coordination of effective referral systems for patients with pre-existing and emerging mental disorders.	Health MHPSS WG

	Explore coping mechanisms and resilient responses	• Emotional regulation (45% of the respondents) • Ability to adapt themselves (54% of the respondents, 45% of youth) • Advocacy capacity to defend community's rights	• Social and psychological issues be addressed simultaneously in a multi-layered, multi-sector approach. Single-intervention approaches require a focus on strengthening the current system, the family, peer support, and the understanding of individuals in a relational perspective.	• Provision of specialized services adjusted and integration of resilient responses	