Construction of health among the Rohingya refugees in Bangladesh: A Culture-Centred Approach

A thesis presented in partial fulfilment of the requirements for the degree of

Doctor of Philosophy

Massey University, Manawatu,

Palmerston North, New Zealand

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2023

Dedication

To all Rohingyas
those who once had citizenship
but are now stateless

Abstract

Rohingyas, the majority of whom are Muslims (followers of the religion of Islam) are the ethnic minority group of the Rakhine state of Myanmar, where they have lived for centuries. However, Rohingyas lost their citizenship rights through a state sponsored apartheid-like system in 1982 and since then they have been stateless. As a result of organised state-led persecutions and even genocide for decades, Rohingyas are now the largest stateless community of the world. It is estimated that around 3.5 million Rohingyas are now scattered throughout the world. Among them, only an estimated 600,000 Rohingyas are still living in Myanmar. However, the exact figure of Rohingyas in Myanmar is difficult to confirm. The largest group, more than 1.6 million Rohingyas, is in Bangladesh. The majority of the Rohingyas once living in Rakhine state of Myanmar fled to Bangladesh after the latest genocide perpetrated against them by the Myanmar authorities from August 2017 onwards. Most of the Rohingyas who fled from Myanmar are now living in 33 makeshift camps at Cox’s Bazar, Bangladesh.

The Rohingyas have been living in the camps of Bangladesh for years without any citizenship rights or refugee status. In this thesis, the Rohingyas are deliberately designated as refugees as they fulfil all the conditions of refugees by various international laws. According to the 1951 Refugee Convention, "a refugee is defined as a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country or to return there because there is a fear of persecution" [Article 1(a)(2), 1951 Refugee Convention].

Bangladesh is not a signatory to the 1951 Refugee Convention or its 1967 protocol and has avoided labelling the Rohingyas as “refugees.” Instead, Bangladeshi authorities refer to the Rohingyas as “Forcibly Displaced Myanmar Nationals” (FDMN) and do not afford them the right to work or freedom of movement. Rohingyas who fled persecution in Myanmar have reason to fear persecution if they return and so they have been staying in the camps for years. In the Bangladeshi camps, while the local authorities and international agencies barely manage to provide minimum basic needs, the Rohingya people suffer from a lack of provisions for long-term needs, such as adequate healthcare services and education.

The current study explores various health issues concerning the Rohingya people living in 33 camps of Cox's Bazar, Bangladesh. To discover their health issues, the localised, lived experiences of Rohingyas have been studied to identify the current health policy approaches and interventions addressing their health needs. This research employs a Culture-Centred ethnographic data collection methodology, with 41 in-depth interviews including some Focused Group Discussions. Purposive and snowballing methods were used to identify and recruit the Rohingya participants. The researcher has applied the Culture-Centred Approach (CCA) to find out the Rohingya refugees’ health needs. The Culture-Centred Approach is a theory of health communication that works through centring culture along with structure and agency and believes the community should have a voice in defining their problems and finding solutions.

This thesis argues that the construction of Rohingya healthcare services at the refugee camps of Bangladesh follow the top-down approach and the services are predetermined by the local authorities and international agencies. The Rohingyas are the passive users of all of their basic needs including the health needs. The voices of Rohingyas are not being heard and

there is no attempt to hear them, even when critical decisions regarding their health and life are being made. From that point of view this thesis examines the lived experiences of Rohingyas living in the refugee camps of Cox's Bazar, Bangladesh through dialogical exchanges between the researcher and the Rohingya refugees. The findings suggest a theory of "looking from below" through the lens of culture, structure and agency that enables a better understanding of Rohingya health issues in the ground-level micro-practices.

The study demonstrates that, given proper opportunities to take part in the decision-making processes, the Rohingyas can improve their health utilising the existing health care facilities of the camps. This thesis also advocates the Rohingya refugees' participation in any community engagement process so as to enable a better life for them in the refugee camps with the limited infrastructures and minimum opportunities. This study also argues for greater Rohingya involvement in medical care to provide facilities that may address the localised, culture-based health needs of the refugee community.

Acknowledgement

At first, I would like to start with the acknowledgement expressing my earnest gratitude to the creator Almighty Allah, the Beneficent, the Merciful. I do believe it is impossible for me without His will, blessings and help to live this life and follow my dreams.

Being a citizen of Bangladesh, I have grown up knowing the life-long sufferings of the Rohingya people who are sheltering at the Cox's Bazar area and living with a limited healthcare service. As a researcher, a journalist, and a pharmacist, I felt the need for this research, and it became my aim to know the health status of Rohingya people living at various refugee camps. However, it was not an easy way for me alone to fulfil my aim. There are so many people who inspired and facilitated me to bring this research to life and I could never sum up all my gratitude in words on a page (or four). However, I will briefly mention a few people who have shaped my thinking and impacted this research project.

I would like to thank my supervisor, research mentor, Professor Mohan J. Dutta, for recognising my talent as a researcher and including my PhD study in the CARE (Centre for Culture-Centred Approach to Research and Evaluation) projects. I also acknowledge and appreciate his support over the years, giving me the chance to work at CARE and peer reviewing my articles throughout the PhD journey that helped me navigate the practical and academic challenges. This research project would not have been possible without his support and guidance. I express my gratitude to Prof. Dutta for nurturing my potential during my work at CARE, my research journey including the PhD field visit by providing invaluable advice and guidance; and finally, for support and encouragement during the write-up of this thesis.

There are too many thanks to my co-supervisor, Dr. Akhteruz Zaman for providing continuous feedback on my research works. When I moved alone to New Zealand, I first met him as he showed his generosity meeting me at Palmerston North Airport. I had a great time with him as he gave me the chance to stay at his residence for some months of my initial days in Aotearoa New Zealand during the COVID-19 lockdown. He guided me to deliver a solution by asking questions and finding logical flaws in every one of my arguments. He spent endless hours reading my research works and giving me feedback, which resulted in improved versions of the PhD thesis.

Special thanks to the CARE family for their continuous support and camaraderie, particularly my CARE Lab mates Phoebe Elers, Pooja Jayan and Christine Elers for sharing not only their space but knowledge and words of encouragement. Their profound insight and knowledge in the field of health communication using Culture-Centred Approach (CCA) proved indispensable to my research. Thanks to Francine Whitefield for the numerous cups of calming coffee and words of appreciation. A special thanks to Richard Torres and Breeze Mehta for providing technical and organisational support whenever necessary.

I am enormously indebted to the Rohingya participants, without whom my research work would not have been possible. I would like to thank all the Rohingya people living in various camps of Cox's Bazar, Bangladesh. At the beginning of my PhD fieldwork, I was a little bit worried to ask a group of oppressed and stateless people, who have been struggling to survive, about their lived experience at the camps. However, understanding their struggles and getting involved in their everyday works gave me a chance to know them all, and to develop an understanding of what the dimensions of health mean to them. I am grateful to all my research participants who devoted their time to share their life stories with me.

While working as a Research Assistant at CARE, Massey University I also worked with the Rohingya refugees living in Palmerston North, New Zealand. There are around 50 Rohingya families living in Palmerston North who resettled in this city through the third country resettlement process of UNHCR. The in-depth interviews I conducted for various projects of CARE helped me to sharpen my knowledge on the Rohingya crisis. I am thankful to all Rohingya research participants in New Zealand. I would like to convey my gratitude to two Rohingya Community researchers, Akbar Shah bin Mohd Sharif and Haji Mohamad Amin Bin Mohamad who helped me to get entry into the Rohingya community of New Zealand.

A heartfelt thanks to Engineer Mostafizur Rahman, my former workstation colleague from BTV (Bangladesh Television) who enabled me to gain access to the Rohingya camps of Cox's Bazar and who was always there as a shoulder to cry on. During my PhD fieldwork I stayed at the BTV rest house in Ukhiya, Cox's Bazar and at that time Engineer Mostafizur Rahman extended his support in finding out ways to enter the Rohingya camps and select the Rohingya interpreter. My special thanks to BTV Cox's Bazar correspondent Jahid Sarwar Sohel, who helped me and showed me the way to get RRRC (Refugee Relief and Repatriation Commissioner) Office permission in the shortest possible time. I started to work on the Rohingya refugee crisis in August 2017 while I worked as a News Producer in BTV. My PhD topic is also related to the Rohingya crisis and so I convey my profound gratitude to all my BTV colleagues who supported me in dealing with the Rohingya crisis.

My sincere thanks to my parents Md Motahar Hossain and the late Rehana Begum for laying the groundwork upon which my life journey is founded, and honest gratitude and thanks to my father-in-law Hosney Jamal Dalim and mother-in-law Khaleda Khanom for giving me their continuous support. I express my love and affection to my younger brother Md Nazrul

Islam, brother-in-law Rafiul Hossain Shihab, and sisters-in-law Sumaiya Afroz and Sharmin Afroze, because they constantly motivated and supported me throughout my PhD journey.

A special thanks to my spouse, Afia Afroj Soma for providing me with unfailing support and continuous encouragement throughout my years of study and through the process of researching. I am also indebted to my two kids; Sajid Rahman Arno and Farija Rahman Arpi as they are living a lonely life in Bangladesh, keeping me in New Zealand for my research work. Doing a PhD overseas means three to four years apart from the loved family members and that is very much true in my life. I convey my thanks to all my family members for their unconditional love and sacrifices which make my PhD journey possible. They are the source of motivation and inspiration for me every day!

Lastly, I would like to thank Prof. Stephen Croucher for his great support and leadership as department chair and MBS (Massey Business School), Manawatu colleagues for their trust, encouragement, and help during my PhD studies. As a special note, I acknowledge that my PhD project has been sponsored by CARE (Centre for Culture-Centred Approach to Research and Evaluation), Massey University.

Research outputs

The following articles, reports, and conference papers have been published based on, or including aspects of, this research:

Journal articles

Published articles:

1. **Rahman, M. M.** (2023). "Health Means Just to Live" at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention. *Global Journal of addiction & Rehabilitation Medicine, 7*(2), 555710. https://doi.org/10.19080/GJARM.2023.07.555710.

2. **Rahman, M. M.** & Dutta, M. J. (2023). The United Nations (UN) card, identity, and negotiations of health among Rohingya refugees. *International Journal of Environmental Research and Public Health. 20*(4), 3385. https://doi.org/10.3390/ijerph20043385.

3. Dutta, M. J. & **Rahman, M. M.** (2022). The city eats the worker: Migrant negotiations of COVID-19 and resistance amidst the COVID-19 crisis. *Consumption Markets and Culture*, 1-16. http://dx.doi.org/10.1080/10253866.2022.2152443.

4. **Rahman, M. M.** (2022). Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh. *Indiana Journal of Humanities and Social Sciences, 3*(9), 22-31. https://doi.org/10.5281/zenodo.7123481.

5. Dutta, M.J., Jayan, P., Elers, P., Elers, C., **Rahman, M. M.** & Pokaia, V. (2022). Receiving healthcare amidst poverty during the COVID-19 lockdowns: A Culture-Centered interrogation. *Health Communication*, 1-7. https://doi.org/10.1080/10410236.2022.2111634.

6. Dutta, M. J., Ramasubramanian, S., Barrett, M., Elers, C., Sarwatay, D., Raghunath, P., Kaur, S., Dutta, D., Jayan, P., **Rahman**, **M. M.**, Tallam, E., Roy, S., Falnikar, A., Johnson, G.M., Mandal, I., Dutta, U., Basnyat, I., Soriano, C., Pavarala, V., Sreekumar, T. T., Ganesh, S., Pandi, A.R., & Zapata, D. (2021). Decolonizing Open Science: Southern Interventions. *Journal of Communication, 71*(5), 803-826, 1-24. https://doi.org/10.1093/joc/jqab027.

7. **Rahman, M. M.**, Mohajan, H. K & Bose, T. K. (2021). Future of Rohingyas: Dignified Return to Myanmar or Restoring Their Rights or Both. *IKAT-The Journal of Southeast Asian Studies, 4*(2), 145-170. https://doi.org/10.22146/ikat.v4i2.57706.

Accepted/Submitted articles:

1. **Rahman, M. M.,** Dutta, M. J. & Elers, P. (2023) (Submitted). Living through food rations: A culture-centered study with Rohingya refugees. *International Journal of Communication*.

2. **Rahman, M. M.,** Elers, P. & Dutta, M. J. (2023) (Submitted). "The beggar's life is better than us": A culture-centered study in Rohingya refugee camps. *Journal of International & Intercultural Communication*.

3. **Rahman, M. M.** (2023) (Accepted). Statelessness – the Root Cause of the Rohingya Crisis – Needs to Be addressed. *New Lines Institute for Strategy and Policy, USA.*

Articles under review:

1. **Rahman, M. M.** & Dutta, M. J. (2023). Post resettlement health disparities of Rohingya refugees in Aotearoa New Zealand: A Cultured Centred interrogation.

2. **Rahman, M. M.** & Dutta, M. J. (2023). Rohingya refugees at the "margins of the margins:" Theorizing erasure, citizenship loss, and violence.

Book chapters

1. **Rahman, M. M. &** Dutta, M. J. (2023). The COVID-19 Pandemic's Impact on the Health of Rohingya Refugees. In S. Kaur-Gill & M. J. Dutta (Eds.), *Migrants and the COVID-19 Pandemic* (pp. 51-67). Palgrave Macmillan. https://link.springer.com/chapter/10.1007/978-981-19-7384-0_3

2. Dutta, M. J., Kaur-Gill, S., Elers, N.H.C., **Rahman**, **M. M.**, Jayan, P., Mandal, I., Pokaia, V. & Matuamate, S. (2023). Justice-based public pedagogy of care: The organizing work of the Center for Culture-Centered Approach to Research and Evaluation (CARE). In J. G. Burchfield & A. A. Kedrowich (Ed.), *Teaching Communication across Disciplines for Professional Development, Civic Engagement, and Beyond* (pp. 311-326). Lexington Books.

3. Kumar, R. & **Rahman, M. M.** (2021). Rohingya health. In Crawford, P. & Kadetz, P. (Eds.), *Palgrave Encyclopedia of the Health Humanities* (Online book).

Academia Letters

1. **Rahman, M. M.** (2022). Term 'Rohingya' accepted worldwide but still taboo in

Myanmar. *Academia Letters.* Article 5788. https://doi.org/10.20935/AL5788.

White paper

1. Dutta, M. J., Jayan, P., **Rahman, M. M.,** Elers, C. & Whittfield, F. (2022). A culture-centered approach to community-led social cohesion in Aotearoa New Zealand. *CARE, Massey University*. White Paper; 22 February 2022. https://carecca.nz/wp-content/uploads/sites/68/2022/03/CARE_White_Paper_Issue_14_22_February_2022.pdf.

2. Dutta, M. J., Jayan, P., **Rahman, M. M.,** Elers, C. & Whittfield, F. (2021). A culture-centered approach to hate speech regulation. *CARE, Massey University*. 12 August 2021. https://carecca.nz/2021/08/17/care-white-paper-issue-12-august-2021-a-culture-centered-approach-to-hate-speech-regulation/.

NZ Govt. report

1. Dutta, M. J., Jayan, P., Elers, C., **Rahman, M. M.,** Whittfield, F., Elers, P., Metuamate, S., Pokaia, V., Jackson, D., Kerr, B., Hashim, S., Nematollahi, N., Teikmata-Tito, C., Liu, J., Raharuhi, I., Zorn, A., Bray, S., Sharif, A.S.B.M., Holdaway, S. & Kake-O'Meara, C. (2021). Community-led culture-centered prevention of family violence and sexual violence. *CARE, Massey University*. A Report submitted to New Zealand Govt. https://carecca.nz/wp-content/uploads/sites/68/2021/11/CARE-JVBU-Violence-prevention-needs-of-diverse-communities-Report.pdf.

   (To formulate the NZ Govt. report 197 in-depth interviews were conducted and among the interviews 14 in-depth interviews of Rohingya people living in Aotearoa New Zealand were taken)

Newspaper and other online news portal articles

1. **Rahman, M. M.** (2023, February 21). The Rohingyas in No Man's Land have fled to Bangladesh. *Refugee Research Online*. https://refugeeresearchonline.org/the-rohingyas-in-no-mans-land-have-fled-to-bangladesh/.

2. **Rahman, M. M.** (2022, August 17). Rohingya repatriation: Various actors need to be considered. *Refugee Research Online*. https://refugeeresearchonline.org/rohingya-repatriation-various-actors-need-to-be-considered/.

3. **Rahman, M. M.** (2022, April 07). Field visit involvements at Rohingya refugee camps of Cox's Bazar, Bangladesh. *Act for Displaced*. https://actfordisplaced.org/2022/04/07/field-visit-involvements-at-rohingya-refugee-camps-in-coxs-bazar-bangladesh/.

4. **Rahman, M. M.** (2021, March 02). Military coup in Myanmar and future of Rohingya repatriation. *The Asian Age*. https://dailyasianage.com/ep/2021/03/02/?page=7.

5. **Rahman, M. M.** (2020, November 23). Myanmar election 2020 and Rohingyas' future. *The Asian Age*. https://dailyasianage.com/ep/2020/11/23/?page=7.

Conference presentations

1. **Rahman, M. M.** (2023). *Rohingya refugee negotiations of COVID-19 at the "margins of the margins."* Presenter at the ICA CARE Pacific Hub Workshop organised by CARE (Center for Culture-Centered Approach to Research and Evaluation), Massey University at Palmerston North, New Zealand. The link of the panel discussion (Hybrid - Online & In-person): https://youtu.be/_qd-td7H2JA.

2. **Rahman, M. M.** & Dutta, M. J. (2022). *Refugee organising at the margins*. Panel presenter at the CARE 10th Anniversary Conference 2022 (28 Nov-02 Dec 2022). https://youtu.be/IB3y3Z4wBcw.

3. Basnyat, I., Kaur, S., Kumar, R. Hajjaj, N. & **Rahman, M. M.** (2022). *'Health Inequities, Communicative Inversions and Structural Barriers in the Health Experiences of Spatially and Systemically Displaced Refugees, Migrants, and Low-wage Workers.'* Panel presenter at the conference of ICA 2022, Paris, France.

   [A hybrid panel discussion session where Iccha Basnyat and Satveer Kaur attended in-person from ICA Conference venue, Paris, France and Raati Kumar, Noura Hajjaj and Md Mahbubur Rahman attended online through Zoom]

4. **Rahman, M. M.** & Dutta, M. J. (2021). *Negotiations of Health Among Rohingya Refugees in Cox's Bazar, Bangladesh: A Culture-Centered Approach to Health and Care*. Extended Abstract presented at the International Communication Association (ICA) Conference -2021.

   [The presentation was held online and then discussion on that topic was held at ICA Hub organised by CARE (Center for Culture-Centered Approach to Research and Evaluation), Massey University at Palmerston North, New Zealand. The presentation and discussion link on the Extended Abstract: https://youtu.be/FmlqyP9dcLc]

5. Whitefield, F., **Rahman, M. M.** & Pitaloka, D. (2021). *'Trauma and Method in the Global South.'* Panel presenter at the preconference of ICA organised by CARE (Center for Culture-Centered Approach to Research and Evaluation), Massey University at Palmerston North, New Zealand. The link of the panel discussion (Hybrid - Online & In-person): https://youtu.be/0sq7cesFjPM.

Articles used as a chapter/part of chapter in this thesis:

Based on my pilot study in February 2020 and fieldwork in December 2021-January 2022 at Rohingya refugee camps of Bangladesh, seven scholarly articles which have been authored/co-authored by me, are incorporated as a chapter or part of chapter of this thesis. The status of the articles and respective page no. is given below:

Sl. No.	Type of the paper (Journal/Institute Name)	Name of the Article/paper/Academia letter	Status	Page no. in this thesis
01	**Academia Letter** (Academia Letters)	Term 'Rohingya' accepted worldwide but still taboo in Myanmar	Published (In 2022)	21
02	**Journal article** (Indiana Journal of Humanities and Social Sciences)	Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh	Published (In 2022)	181
03	**Journal article** (Global Journal of Addiction & Rehabilitation Medicine)	"Health means just to live" at the Rohingya camps of Bangladesh: A Culture-Centred intervention	Published (In 2023)	238
04	**Journal article** (International Journal of Communication)	Living through food rations: A culture-centered study with Rohingya refugees	Submitted (In 2023)	263
05	**Journal article** (Journal of International & Intercultural Communication)	"The beggar's life is better than us": A culture-centered study in Rohingya refugee camps	Submitted (In 2023)	296
06	**Online Newspaper article** (Refugee Research Online)	Rohingya repatriation: Various actors need to be considered	Published (In 2022)	352
07	**Invited article** for a Think Tank organisation of USA. (New Lines Institute for Strategy and Policy)	Statelessness – the Root Cause of the Rohingya crisis – Needs to Be Addressed	Accepted (In 2023)	359

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Glossary

Boat People: Boat people is a term to describe refugees fleeing by boat. The term first appeared in academia in the late 1970s to describe the mass exodus of Vietnamese refugees from Vietnam following the Vietnam War. From the 2000s the term ‘boat people’ has been the complementary word for Rohingya refugees who voyaged through sea by the wooden boats to flee from Myanmar.

IDP (Internally Displaced Persons) Camps: Since the 2012 communal violence, around 140,000 Rohingyas have been living in IDP camps in Myanmar. In Myanmar, Rohingyas have been given shelter in 68 IDP camps situated in the Rakhine state.

FDMN (Forcibly Displaced Myanmar Nationals): Government of Bangladesh (GoB) has labelled the Rohingyas who entered Bangladesh after August 2017 as FDMN but not as refugees.

GoB (Government of Bangladesh): Bangladesh is a unitary state and the central government which has the authority to govern over the nation is known as GoB. The Prime Minister, who must be a Member of Parliament (MP), is the head of GoB.

JRP (Joint Response Plan): It is a yearly plan containing needs assessments, consultations, and strategic planning for the Rohingya refugees. Initially JRP was formulated only for the Rohingya communities, however from 2018 host communities are also included in JRP.

LCs (Learning Centres): The centres, situated at the camps, established by local and international aid partners that provide basic education to the Rohingya children are known as Learning Centres (LCs). Currently there are around 3,400 TLCs providing basic education to over 400,000 school-aged Rohingya children of the camps.

Majhi: Majhi (literally in English as ‘boat steersman’) is a community leader of the Rohingya refugees. The Bangladesh Army set up the 'majhi system’ in the 1990s at the Rohingya camps to organise humanitarian assistance for the refugees. However, after the 2017 exodus the majhi system was again introduced at the Rohingya camps. The majhi is a Rohingya community representative, usually a man, informally selected by camp authorities to support officials in maintaining law and order and act as a focal point for camp management activities.

NUG (National Unity Government): The National Unity Government of the Republic of the Union of Myanmar is a Myanmar government in exile formed by the parliamentarians elected in the 2020 election, ousted in the 2021 Myanmar coup d'état.

Tatmadaw: In Myanmar, Tatmadaw means armed forces or military. It is administered by the Ministry of Defence and composed of the Myanmar Army, the Myanmar Navy, and the Myanmar Air Force.

UMN (Undocumented Myanmar Nationals): UMN is the name of the Rohingyas given by the GoB who entered Bangladesh before 2017.

Upazila (Bengali word for sub-district): A third administrative unit comprising several union councils and upazila parishad institutions. After divisions and districts, the third largest tier of administrative units in Bangladesh is called upazila.

Acronyms

BRAC: Bangladesh Rural Advancement Committee

BTV: Bangladesh Television

CARE: Centre for Culture-Centred Approach to Research and Evaluation

CCA: Culture-Centred Approach

CIC: Camp In-Charge

EWARS: Early Warning, Alert and Response System

FGD: Focus Group Discussion

LPG: Liquefied Petroleum Gas

GOARN: Global Outbreak Alert and Response Network

MoHFW: Ministry of Health and Family Welfare

NCD: Non-Communicable Disease

NGO: Non-Government organisation

RRRC: Refugee Relief and Repatriation Commissioner

TLC: Temporary Learning Centre

UN: United Nations

UNHCR: United Nations High Commissioner for Refugees

UNICEF: United Nations International Children's Emergency Fund

WFP: World Food Programme

WHO: World Health Organisation

Chapter 1: Introduction

1.1 Introducing the research problem

This study explores various health issues concerning the Rohingya people living in 33 makeshift camps at Cox's Bazar, Bangladesh. Cox's Bazar is one of the 64 districts of Bangladesh, situated in the south-eastern part of the country. Cox's Bazar shares a 62-kilometre border with Myanmar and this area is separated from Myanmar by the Naf River (Xchange, 2018). The Rohingyas, who fled sustained persecutions in Myanmar to many countries including neighbouring Bangladesh, have been identified by the United Nations as the largest stateless community in the world (Gaffar, 2018; Khanna, 2020; Kiragu et al., 2011; Rahman & Mohajan, 2019; Rahman & Sakib, 2021). They have neither citizenship rights in Myanmar nor refugee status in Bangladesh. After just six years of independence of Bangladesh, through the first exodus in 1977-78, these Rohingyas started to live mainly in Cox's Bazar and some of them in the nearby Bandarban and Chittagong (presently known as Chattogram) district (Khatun, 2017; Parnini, 2013).

There have been four additional major influxes of Rohingyas to Bangladesh and these influxes took place in 1991, 2012, 2016, and 2017 respectively (Habib, 2021; Macdonald et al., 2023; Selth, 2018). Besides the major influxes, Rohingyas always entered Bangladesh whenever they faced any crisis in the Rakhine state of Myanmar, taking advantage of the porous border between Bangladesh and Myanmar (Khuda, 2020, Rahman et al., 2021). Currently the total number of Rohingyas staying in Bangladesh stands at over 1.6 million. Of them, some have already been integrated into the local community, only 33,519 Rohingyas

are registered as “refugees,” and the rest of the Rohingyas living at the camps are registered as “FDMN (Forcibly Displaced Myanmar Nationals)” (Ahmed, 2021; Faiz et al., 2022).

In Bangladesh, the Rohingyas registered as refugees have been living in two camps since 1992 and these camps are named Kutupalong and Nayapara registered camps (Nielsen et al., 2012). The rest of the Rohingyas labelled as FDMN live in 32 refugee camps of Cox’s Bazar. Although these 32 camps were erected following the 2017 influx of the Rohingyas to house new arrivals, both new and old arrivals registered with Bangladesh authorities as FDMN are currently living in them. Among the 34 camps of Cox’s Bazar, one camp was closed by the Bangladesh government in 2021, and the residents of the camp were relocated to other camps of Ukhiya and Teknaf and so now there are 33 makeshift Rohingya camps available in Cox’s Bazar (JRP, 2022; WFP Situation Report, 2021). In these camps the local authorities and international agencies hardly manage to provide minimum basic needs like shelter and food. However, the Rohingya people suffer from a lack of long-term needs of life, such as adequate healthcare services and education. To explore their health issues, I engage with the lived experiences of Rohingyas by adopting the Culture-Centred Approach (Dutta, 2008) to identify the current health policy approaches and interventions addressing their health needs. I will explore what may be the causes either their stateless identity or any other issue that hinder Rohingya refugees to get the proper healthcare needs while living in the refugee camps of Bangladesh. I will also delve into the probable solutions of the decades long Rohingya crisis.

1.2 Research questions

In this research, the Culture-Centred Approach (CCA), a theory of health communication, is used to dialogically co-construct the experiences of health of the Rohingya refugees living in Bangladesh and to foreground their localised experiences to suggest entry points for change in health policies and interventions addressing their needs (Dutta, 2008; Dutta-Bergman, 2004a, 2004b). Historically, the Rohingya people have had no access to healthcare for decades due to inadequate health services and restrictions on their freedom in Rakhine state in Myanmar (Riley et al., 2020). For those Rohingyas who are now living in the Bangladeshi refugee camps, the stakeholders (local and international) are trying to provide emergency or basic medical care to them (Saiyed et al., 2018). With very limited or no access to medical care in Myanmar, the Rohingyas staying in Bangladesh have serious health needs, but they have to live in the congested camps with limited access to healthcare services.

With the support of UN agencies, nongovernmental organisations (NGOs), and donor countries, Bangladesh is serving the huge Rohingya community. However, although the basic health needs of Rohingyas are being addressed, their voices have never been heard, rather they are given last-minute information campaigns (Sullivan, 2020). The Rohingyas are somehow erased from the mainstream healthcare interventions as they are not allowed to access the public health services of Bangladesh outside of the camps. Inside the camps, they are the end users of health where the services are provided through a traditional top-down approach. Noting such erasure of voices, this study seeks to foreground the voices of the Rohingya community, revealing the complexity of the culture surrounding healthcare-seeking practices while grappling with structural barriers by asking the following questions:

01. What does health mean to Rohingya refugees in Bangladesh?

02. What are the challenges to health the Rohingya refugees face?
03. How do the Rohingya refugees negotiate the health challenges?
04. What is the role of communication in the context of Rohingya negotiations of health?
05. What is the relationship between voice, statelessness, agency in negotiating the challenges of health that Rohingya refugees face?
06. How do Rohingya refugees employ their agency in achieving the solutions they want to foresee?

To discover the health needs of Rohingya refugees, I will engage myself to find out what the real cause of Rohingyas may be not to get proper healthcare services at the camp level. In this research, I will explore to see, is it their stateless identity or their absence of voice at the decision table or both, that lead to poor healthcare services at the camp level. As the Rohingyas do not have any identity document, Bangladesh, which is currently the home of the majority of Rohingya population, ignores various rights including the health rights of Rohingyas (Rahman & Sakib, 2021). Although Rohingyas have been living in Bangladesh since 1977, they are not present in any decision-making process that matters of everyday camp life of Cox's Bazar (Sullivan, 2020). In this research, I will use the Culture-Centred Approach (CCA) to open up the Rohingyas' voice responding to get the health needs at the camp level. Based on the above-mentioned research questions, I will try to find out the Rohingyas voice infrastructure to build a 'theory from the below' which is the basis of the Culture-Centred Approach (CCA).

1.3 Rationale and importance of research

The Rohingya community does not have any recognition in Myanmar, and this issue is a predicament for Bangladesh. Before 2017, about 400,000-500,000 Rohingya were already living in the Cox's Bazar, Bandarban, Khagrachari and Rangamati districts of Bangladesh. These Rohingyas entered Bangladesh at different times between 1977 and 2017 (Milton et al, 2017). After the August 2017 Rohingya crisis, 742,000 Rohingyas were added to this number, followed by 12,000 more in 2018 (UNHCR, 2019a). As a result, Bangladesh is now hosting an estimated over 1.6 million Rohingyas, and among them some thousands or more are already integrated into the local community of Cox's Bazar, Chattogram (previously known as Chittagong) and live like Bangladeshi citizens. Since December 2020, Bangladesh has taken steps to transfer some thousands of Rohingyas to Bhasan Char from the Cox's Bazar camps. However still over 900,000 Rohingyas are living in the 33 makeshift refugee camps of Cox's Bazar (JRP, 2022; UNHCR, 2022a; UNICEF, 2023a).

This research addresses the health conditions, situations, barriers to accessing health needs, and proposed solutions by the Rohingya refugees living in Bangladesh, and it is the primary concern of this study. Having experienced historical human rights violations in Myanmar, Rohingya refugees are now bound to cope with difficult and congested living conditions in the 33 makeshift camps of Cox's Bazar. The Rohingya refugees have been deprived of their basic human rights of healthcare, employment, education, and freedom of movement (Wali et al., 2018). Rohingya people continue to experience barriers in accessing and receiving their health care needs mainly because of a shortage of the healthcare facilities, and because of the increased number of refugees living in a limited space of the camps of Cox's Bazar. This study documents the lived experiences of Rohingya refugees through the lens of culture,

structure, and agency (the main tenets of CCA) by dialogic venture between the Rohingya participants and the researcher.

There are a few accessible studies regarding the overall health issues of Rohingya refugees living at the camps of Cox's Bazar, Bangladesh. However, none of these adopted the Culture-Centred Approach (CCA) to find out the health needs of the refugees at any refugee camp. For the Rohingyas, who are one of the most marginalised and vulnerable communities in the world, the Culture-Centred Approach (CCA) to health would be appropriate as CCA advocates for the people of the "margins of the margins" (Dutta, 2018). Building on the framework of the CCA, conceptualising dialogue as a mediation that brings subaltern voices (Dutta & Pal, 2010; Dutta, 2014), this study finds out the health needs of the Rohingya refugees. Understanding the health status of Rohingya refugees living at the camps and the recommendations put forth by the participants, this research will help the host country, local and international agencies and the public to come up with some new plans to improve health strategies of Rohingyas living in Bangladesh.

1.4 Theoretical framework

The Culture-Centred Approach (CCA) to health communication provides the theoretical lens of this study. The three key strands of the Culture-Centred Approach - culture, structure, and agency are utilised to identify locally meaningful problems and the corresponding localised solutions that are directed at addressing the health problems of any community (Dutta-Bergman, 2004a, 2004b; Dutta, 2008). CCA in health communication is formed on the principle of listening to the cultural voices of any community and then offering probable solutions (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b, 2005). In CCA, the

commitment of writing theory is formed 'from the below' with the engagement of "margins of the margins" who have traditionally been silenced or erased by the dominant theories and models of health communication (Dutta, 2007, 2014).

Traditional health communication approaches adopt a unilinear, top-down model to know the health disparities of a community and then propose health programs and policies to address the disparities (Airhihenbuwa, 1995; Basu, 2010; Dutta, 2008; Malikhao, 2020). These Western or US based health communication models are built under the modernisation paradigm which assumes that the Western way of living should be adopted everywhere for any development purpose (Malikhao, 2020). In these traditional models, health professionals acquire knowledge through formal or informal education and then pass it to receivers, aiming to inform, educate, upgrade, or train them on good public health practices (Malikhao, 2020). These models harbour the idea of one-way transmission of health knowledge, information, and belief from core health sector workers to end users without considering the users' voices in any meaningful way (Jamil & Dutta, 2012).

In traditional western models of health, the voices of the marginalised populations who are most affected by health inequities are totally absent in any decision-making process, but they are treated as the "targets" of health communication interventions (Basu & Dutta, 2009; Dutta, 2007, 2008; Dutta & Basu, 2011). Again, culture has been poorly examined or even not considered at all in the context of dominant health communication approaches (Dutta, 2007). Culture had also been absent in health communication research for a long time as scholars and practitioners worked under the universalist notions of dominant health communication approaches (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b; Dutta, 2008; Dutta & Basu, 2011; Lupton, 1994). To challenge the backdrops of traditional western

models of health, CCA emerges as a framework which acknowledges that, in case of health inequities, dynamic interactions between culture, structure, and agency work as entry points to theoretical insights into how health decisions and meanings are negotiated in cultural communities (Jamil & Dutta, 2012). As a result, in the last couple of decades, there has been a significant turn by the concerned health communication experts towards Culture-Centred Approach to health, especially for the marginalised people of the world (Khan et al., 2019) and Rohingya refugees are the most marginalised and persecuted people of the world.

Traditional western health models rely heavily on positivism which is based on natural science models of cause and effect, and they work through intrapersonal communication that seem to assume direct relationships between knowledge, attitude, and behaviour regardless of the context or community within which people live (Malikhao, 2020). These high-tech traditional models totally ignore the process of listening to the end users. But the Culture-Centred Approach is founded upon the notion of listening to the communities at the "margins of the margins" offering an entry point to addressing the health inequities that are produced by neoliberal globalization (Dutta, 2012).

The Rohingya refugee community living in Bangladesh camps is a perfect example of "margins of the margins" as they have been living in the margins for decades (Islam & Naing, 2023). Rohingyas' marginalisation has been created by the Myanmar government as it denies their citizenship rights and prolonged in Bangladesh camps as the Bangladesh government does not recognise them even as refugees (Bhatia et al., 2018). In Culture-Centred Approach, the researcher's participation shifts into the role of a listener and participant in the conversation rather than the expert/authority role a researcher plays in more traditional health methods. Dutta (2008) argues that CCA seeks to foster theoretical openings

based on conversations/dialogue between subaltern/marginalised communities (like the Rohingya refugee communities) and academics in a process of co-construction of knowledge.

CCA is a framework for addressing health inequalities by building communicative infrastructures through listening to the voices of subaltern/marginalised communities like the Rohingya refugee communities that are hitherto erased from dominant discursive spaces (Dutta, 2018). In CCA, dialogue is encountered with in-depth interviews and these in-depth interviews build the communicative infrastructure for knowledge generation (Dutta, 2018). Based on the CCA framework, in-depth interviews at the community level are utilised to understand the communication needs of the local communities, to explore their communication capacity requirements for the development of the community solutions, and to co-create dialogues that generate theories of health from the "margins of the margins." (Dutta-Bergman, 2004a, 2004b; Basnyat, 2014; Yehya & Dutta, 2010). So, the Culture-Centred Approach (CCA) is used as the theoretical framework of my research on the construction of health in the realm of health communication scholarship among the Rohingya refugees.

1.5 Research positionality

The co-construction of the meaning of health by the Rohingya people in Bangladeshi refugee camps requires developing rapport with them, understanding the Rohingya perspectives, and establishing bonds of trust with them. I am in a unique position in developing this connection with the Rohingya refugees through my roles, first as a journalist and then as a researcher, in Bangladesh and abroad. The mainstream Bangladeshi society do not want Rohingyas to be integrated in the local society or even do not want them to stay in Bangladesh for a longer

period of time. However, I as a journalist and researcher, always show my solidarity with Rohingyas' long struggle and try to put my efforts to advocate for their rights either by academic works or by my continued involvement with them even in New Zealand.

For my PhD fieldwork, I spent 22 days (from 20 December 2021 to 10 January 2022) at the Rohingya refugee camp area of Cox's Bazar, Bangladesh and conducted 41 in-depth interviews of Rohingya men and women utilising the Culture-Centred Approach. During my PhD fieldwork, I visited five of the 33 makeshift refugee camps, situated at Ukhiya upazila (sub-district) of Cox's Bazar, Bangladesh. Besides, in February 2020, I stayed at Cox's Bazar for three to four days and took 12 interviews of Rohingya refugees living at Kutupalong refugee camp, as a pilot study of my PhD research. In 2018, I visited the camp area for the first time as a television journalist, talked to the Rohingya refugees and covered the camp visit by the UN Secretary General Antonio Guterres for the public service TV station, Bangladesh Television (BTV).

At Bangladesh Television I was responsible for producing visual news stories of the Rohingya crisis since the latest Rohingya exodus to Bangladesh in August 2017. Since then, I have produced over 100 visual news reports on the Rohingya issue and broadcast them in both Bangla (or Bengali) and English language national bulletins. At that time, I was stationed in Bangladesh's capital Dhaka and worked from the central newsroom of BTV. In covering the crisis, I closely liaised with the local correspondent of BTV who was stationed in Cox's Bazar and frequently visited the Rohingya camps. I have also produced a 12-minute documentary titled "'বাংলাদেশে জাতিসংঘ মহাসচিব – রোহিঙ্গাদের ভবিষ্যৎ' 'UN Secretary General in Bangladesh – Future of Rohingyas'" in the Bangla language for the state broadcaster.

Besides, while working as a Research Assistant of CARE (Centre for Culture-Centred Approach to Research and Evaluation) at Massey University, New Zealand, I have been engaging with Rohingya refugees resettled in Aotearoa New Zealand through the third country resettlement process. I have conducted more than 50 in-depth interviews of Rohingya refugees living in New Zealand for the projects titled, 'Experiences of COVID-19 among low-income households'; 'Culture-Centred engagement with diverse communities on violence (family violence and Sexual violence) prevention;' and 'Rohingya everyday meanings of health.'

These extensive engagements have enabled me to develop a rapport with and an advanced level of understanding of the Rohingya perspectives. My strong connection with the Rohingya issue is an essential element of the theoretical perspective adopted in this exploration of the co-construction of health by the Rohingya people.

1.6 Thesis outline

This thesis is divided into eight chapters that examine and analyse the health issues of Rohingya refugees living in Bangladesh.

Chapter 1 introduces the research problem, outlines the research questions, and discusses the rationale and importance of the research. This chapter elaborates the rationale for utilising the Culture-Centred Approach (CCA) to find out the health status of Rohingya refugees. It also provides an outline of the thesis.

Chapter 2 describes the Rohingya context — the origin of the term 'Rohingya' and the historical background of Rohingya in Myanmar, as well as the Rohingya exodus towards Bangladesh. This chapter also discusses the legal status of Rohingyas in Bangladesh and their right to access to healthcare in Bangladesh.

Chapter 3 reviews literatures relevant to the study, in an attempt to gain a current and relevant scholarly understanding of Rohingya health. It reviews literature on the Culture-Centred Approach (CCA) to refugee/Rohingya health, the health status of Rohingyas in Myanmar and in Bangladesh, available health facilities in Bangladesh for Rohingyas, existing health infrastructures at the Rohingya camps and the process of health problems negotiated by Rohingya refugees.

Chapter 4 sets up the theoretical and methodological framework for studying Rohingya health. The chapter argues the importance of using the Culture-Centred Approach to co-construct the voices of the Rohingya community members and keeping it to the fore. This chapter highlights the methodological tools used for data gathering, including (a) site selection (b) entry procedure at the research site (c) data collection procedures (d) data analysis and ethical framework.

Chapter 5 presents the results of the qualitative analysis of 41 in-depth interviews including FGD and group discussions. The results present six themes concerning Rohingya health that arise from the line-by-line open coding of the interview scripts. This chapter contains three journal articles written on the basis of the findings of the study.

The research questions – what the meaning of health to Rohingya refugees is, what challenges they face to get the healthcare services and how do they negotiate the health challenges are discussed in this chapter.

Chapter 6 offers an overall discussion of the key findings that are analysed based on the tenets of CCA. This chapter relates the findings to the theoretical and methodological assumptions of CCA, which is the overarching theory guiding this research project.

Chapter 7 discusses participants' recommendations to improve the present health conditions within the existing health infrastructures. The highlight of this chapter includes a deeper discussion on the development process of Rohingya health. This chapter also highlights the recommendations to solve the decades long Rohingya crisis.

Chapter 8 This final chapter closes with a summary of the salient points of the dissertation/thesis. In this chapter concluding remarks are presented with limitations of the study. This chapter also provides recommendations for future research.

In this thesis by publication, I incorporated seven articles. In chapter 2 (Rohingya Context), I put a published academia Letter (first article of my thesis) that describes the present status of the Rohingya ethnicity and the present acceptability of the term 'Rohingya' in Myanmar. In chapter 4 (Research Methodology), I have incorporated a published article (second article of my thesis) that describes the challenges and required strategies I followed while I conducted my PhD fieldwork at the Rohingya refugee camps of Bangladesh.

In chapter 5 (Findings), I have incorporated three articles that I wrote based on my research findings. In this chapter 5, the first article (third in my thesis) describes the meanings of health to Rohingyas, second article (fourth in the thesis) designates the insufficiencies of Rohingyas' food ration affecting their overall health and the last one (fifth article of the thesis) outlines the structural barriers faced by the Rohingya refugees living in the camps of Bangladesh. In chapter 7 (Recommendations and Praxis), I have incorporated another two more articles (six and seventh article in the thesis) outlining various recommendations to solve the overall Rohingya crisis.

Chapter 2: Rohingya Context

2.1 Who are Rohingyas?

Rohingyas are an ethnic minority group of the Rakhine state of Myanmar. The Rakhine state was known as "Arakan" until 1974, and the country changed its name from "Burma[1]" to "Myanmar" in 1989 (Chan, 2005; Faye, 2021; Lindblom et al., 2015; Ty, 2019). Apart from a few hundred Hindus and Christians, the vast majority of Rohingyas are Muslims. In 1982, the Myanmar authorities revoked Rohingya citizenship rights. However, this ethnic minority group has been living in Myanmar since the Eighth Century or even earlier (Ahmed et al., 2021; Al-Mahmood, 2016; Leider, 2018). It is estimated that before the 2017 exodus, Rohingyas constituted 1% of the total population, 4% of the Rakhine state population, and 45% of the total Muslim population of Myanmar (Chan, 2017; Habibollahi et al., 2013). Prior to the latest major violence that began in August 2017, more than one million Rohingyas lived in the Rakhine state of Myanmar (Rahman, 2023a). However, now only an estimated 600,000 Rohingyas are left in Myanmar (Banerjee, 2021; Mostafanezhad et al., 2022). Of the remaining Rohingyas in Myanmar, around 140,000 are staying as Internally Displaced People or IDPs in various prison-like camps (Root, 2023; USAID, 2022; Yhome, 2020). Due to state-led persecutions and violence, Rohingyas are now dispersed throughout the world, having left their motherland Myanmar.

[1] "Burma" was the previous name of present-day Myanmar. In this thesis, the term "Burma" has been used to refer to the country pre-1989, and "Myanmar" to post-1989. At times, they are used interchangeably. Again, Arakan and Rakhine are also used interchangeably in this thesis. The State's name was changed from Arakan to Rakhine in 1974 (Leider, 2022).

Myanmar is a Buddhist-majority state, but the Rohingyas are primarily Muslims. According to the 2014 census of Myanmar, 89.8% of the country's population are Buddhist, 6.3% are Christian, and 2.3% are Muslims (Lynn, 2016). The Rohingyas follow the religion of Islam, belonging to the Sunni sect that maintains a conservative outlook and is based on the Hanafi school of thought or Mazhab. Before 2017, the Rohingyas were the second largest ethnic group in the Rakhine state after the Rakhine Buddhists. They were considered as the largest Muslim group in Myanmar (Martin et al., 2017). Rohingyas speak Rohingya or Ruaingga or Rooinga language, which, as some have observed, is a dialect of the Bengali (Bangla) language. The Rohingya language has some similarities with the Chittagonian dialect but with a different accent, as opposed to the commonly spoken Burmese language (Ahmed, 2009; Hölzl, 2020). The Rohingya language is only a spoken language, not a written one, and is used predominantly by all Rohingyas in the Rakhine state of Myanmar and by the new generation of Rohingyas born in Bangladesh (UNHCR, 2007). Traditionally, Rohingyas live in a community mechanism called "samaj" (the Bengali/Hindi word Samaj means "society" in English) which maintains a strong sense of solidarity and collectivism in the villages/townships (Tay et al., 2018).

The social structure of Rohingyas is patriarchal, positioning men at the apex of family or social hierarchy (Bentil & Adu, 2020). It is the cultural norm of the Rohingyas that women are confined to houses, do household works, and are discouraged from going outside for work (Ripoll, 2017). Male authority figures in families even decide on crucial matters, such as how many children a Rohingya woman can bear or what she wears (Acaps, 2020a). Rohingyas traditionally lived in a large, extended family where the males shared different types of authority. If a male figure is not present, the senior female can take the lead. The traditional Rohingya dresses include the lungi or loincloth for men (A Sarong-style dress also favoured

by Bengali men) and abaya or long skirt down to the ground with a thami blouse for women. In recent years, however, a hijab as the third piece of cloth has become popular with the Rohingya women (Zafari, 2018). The staple food item of Rohingyas is rice (Segnana, 2020; TWB, 2021a).

The Rohingyas are the only ethnic minority group in Myanmar who still face numerous discriminatory obstacles in accessing health, education, travel, marriage, employment, and maintaining religious rituals while living in the Buddhist majority country (Hlaing, 2022; Mithun, 2018; HRW, 2020a). They are not considered as one of the 135 officially recognised ethnic groups of Myanmar. They have been denied citizenship rights since 1982, which has effectively rendered them stateless (Brinham, 2019; Faye, 2021; Ma et al., 2018). In Myanmar, the Rohingyas have faced state-sponsored persecution and endured severe discrimination since the 1970s. For years, they have been living a miserable life in Myanmar, suffering considerable trauma because of the widespread state-led campaign of murder, rape, and arson attacks tantamount to crimes against humanity. Seeing no other options, the Rohingyas have been fleeing from Myanmar in droves, crowded on boats (as boat people) and ping-ponged between various countries that don't want them.

2.1.1 Muslim and Buddhist at Rakhine

Alongside several small ethnic groups, Arakan Muslims (Rohingyas) and Rakhine Buddhists (Maughs/Maghs/Mogs) have coexisted in the area for centuries (Akhtar, 2019; Jha, 2020). The Buddhists of Arakan (Rakhine) are called Maughs by the then Bengali people and by the Arakan Muslims (Rohingyas), and they are different from other Bamars (Burmese Buddhists) of Myanmar (Minar & Halim, 2020). Rakhine Buddhists are called Maughs (Mughs/Maghs)

as they first migrated to Arakan from Magadha or Magadhi (Bihar) during the Chandra dynasty (788-957 AD) of Arakan (Charney, 2005). Bamars (also known as Burmans) are the largest ethnic and linguistic group in present-day Myanmar, accounting for approximately two-thirds of the population (Yoni, 2022). Rakhine Buddhists practise the same religion of Theravada Buddhism, but they are different from the main ethnic group Bamars due to their slightly different language, culture, and geographic isolation caused by the Arakan Yoma Mountain (Sraman, 2006).

According to the 2014 population census, about 90% of Myanmar nationals are Buddhists while only 2.3% are Muslims. However, the Rohingyas remained outside of this enumeration because the authorities tried to label them as “Bengalis” (Ferguson, 2015). It was estimated that at the time of the census, some 1.1 million Rohingya Muslims had been living in the Rakhine state (Ferguson, 2015). Adding this number of Rohingya Muslims would have brought the percentage of Muslim population in Myanmar to 4.61% of its 51 million inhabitants (Lynn, 2016). At the time of the census, a false narrative was circulated around Myanmar to the effect that the majority Buddhists would soon become a minority in the country. However, this was a baseless claim and considered by many as hate speech against Muslims. The Muslim population in Myanmar has remained steady since the 1980s at around four per cent or less of the total population (Schmelzer et al., 2021).

Link One

A part of chapter 2 (2.2) titled, “Term ‘Rohingya’ accepted worldwide but still taboo in Myanmar” has been published as *Academia letters*.

I wrote the respective Academia Letter as requested by the Academia Team. This letter describes the present ‘Rohingya’ status as an ethnicity and as a term in Myanmar. Till today, the term or ethnicity of ‘Rohingya’ has not been accepted by the Myanmar authority though the term ‘Rohingya’ has been accepted worldwide by media, academicians, and international organisations. To formulate the article, I utilised the Rohingya voices those I have collected through my PhD fieldwork and pilot study based on Culture-Centred Approach. Both of my supervisors, Professor Mohan Dutta and Dr. Akhteruz Zaman, provided feedback on the draft of the article.

I have written the letter as per the guidelines of the Academia Letters:

> **Topics:** Submissions can be on any topic of academic study.
>
> **Article length:** Submissions must be between 800 and 1,600 words, excluding references.
>
> **Language:** Submissions must be written in English.
>
> **Reference style:** References are mandatory and can follow any major style — APA, MLA, etc.

I submitted the article (Academia Letter) to the Academia on 12 April 2022, and they published it on 17 July 2022 after peer reviewing.

2.2 Term 'Rohingya' accepted worldwide but still taboo in Myanmar

(A published Academia Letter)

Rahman, M. M. (2022). Term 'Rohingya' accepted worldwide but still taboo in Myanmar. *Academia Letters*. Article 5788. https://doi.org/10.20935/AL5788.

Abstract

Rohingyas are the stateless, mostly Muslim ethnic minority group of people who have been living in Myanmar for centuries, but the country does not recognize their citizenship rights. Even the term 'Rohingya' is still banned in Myanmar though the term has been accepted globally. This short article aims to find out the historical background and present status of the term 'Rohingya,' with information that has been collected from different sources predominantly from scholarly articles and through in-depth interviews of Rohingya refugees living in Bangladesh and New Zealand.

Introduction

'Rohingya' is the ethnic identity of a group of Muslim people who traced their roots in the Rakhine state (Former Arakan state) of Myanmar from 7th or 8th century (Tran, 1996; Faye, 2021). Year after year, the Rohingya Muslims have been persecuted, tortured, and abused by the state-sponsored tactics of Buddhist majority Myanmar (Haar et al., 2019). Having been expelled from Myanmar an estimated 3.5 million Rohingyas are now distributed throughout the world (Albert & Maizland, 2020), with the largest number (more than 1.6 million) of displaced Rohingyas now living in Bangladesh. Of them, around one million are now

sheltering in the 33 refugee camps of Cox's Bazar, a south-eastern district of Bangladesh (Rahman & Mohajan, 2019). From 1982 to now, the authority of Myanmar does not recognize the Rohingyas as citizens or even recognize the term 'Rohingya', although all the members of the Rohingya minority group love the term and are determined to identify themselves as Rohingya.

Etymology of the term Rohingya

Though the etymological root of the word 'Rohingya' is not confirmed, the most widely accepted theory is that the term 'Rohingya' is the combination of two words 'Rohang' and 'ga' or 'gya' (Rohang + gya/ga = Rohingya) (Albert & Maizland, 2020). The word Rohang derives from the word 'Arakan' and ga or gya means 'from' (Pantea, 2019). It is true that the term 'Rohingya' came to the spotlight in the 1950s through the Rohingya movement in Arakan (present Rakhine) state of Myanmar (Leider, 2018). Before the 1950s the Rohingya Muslims had many terms by which they identified themselves or by which the then authority identified them, including the terms of Arakan Muslim, Rakhine Muslim, Musolman, Mohammedan etc. (Smith, 2019; Rahman et al., 2021). However, the label 'Rohingya' has become more prominent in recent times and the group is also interested in identifying themselves by the latest term 'Rohingya.' While taking an in-depth interview by the author, one Rohingya refugee (42-year-old male) living in Cox's Bazar refugee camp mentioned:

> We are Rohingya Muslims. Our father, grandfather, great-grandfather, and ancestors all were Burmese (Myanmar) Rohingya. And our main demand is that they (Myanmar authority) should recognize us as Rohingya as that is our identity and they should return our citizenship rights.

Term Rohingya in literature, Burmese history, International Media

The ‘Rohingya’ relating word ‘Rooinga’ was found in the literature in 1799 mentioned by Dr. Francis Buchanan, a Scottish Physician in his linguistic survey book after his visit to then Arakan area (Buchanan, 1799; Kironska & Peng, 2021). Burma’s first prime minister U Nu, who led Burma in between 1948 and 1962, used the term ‘Rohingya’ at several points (Taylor, 2016). In a public speech on 25 September 1954 mentioning the term 'Rohingya', the then Burma’s prime minister U Nu said, “The people living in Buthidaung and Maungdaw Townships (of Rakhine) are Rohingya, ethnic of Burma” (Lewin, 2012; Washaly, 2019).

Some experts observed that the Burmese Muslim scholar Tahir Ba Tha first used the word ‘Rohingya’ in his essays and other publications in 1960s (Jilani, 2007; Lee, 2019). From 15 May 1961 to 30 October 1965, a Rohingya-language radio programme was broadcast by the official Burma Broadcasting Service (BBS) as a part of its minority language programming, and the term ‘Rohingya’ was used in journals and school textbooks of Burma until the late 1970s (Lee, 2019; Ali, 2022).

The term ‘Rohingya’ started to be used by the international media in 1977-78 when the Rohingya Muslims for the first time were expelled from independent Burma (Myanmar) (Leider, 2020a). Again in 1991-92 the term ‘Rohingya’ or Rohingya people drew global media attention by their misery through the expulsion from Myanmar (HRW, 2009). Then in 2017 after the latest exodus of Rohingya from Myanmar, almost all news channels and agencies, social and human right activists, journalists of the world have addressed the Rohingya crisis utilizing the term ‘Rohingya’ (Washaly, 2019).

Rohingya complementary term for ‘boat people’

Since 2007 to date the word ‘Rohingya’ has been used as a complementary term for ‘boat people.’ The term ‘boat people’ belongs to the stateless ‘Rohingya’ community who desperately start their journey either from Myanmar or Bangladesh to reach a developed state only by means of wooden boats risking their lives (Lewa, 2008; Roy Chowdhury & Abid, 2022). The UNHCR mentioned that, from January to May 2022 some 630 Rohingya had attempted sea journeys across the Bay of Bengal and many of them may have died or gone missing (Reuters, 2022b).

Term Rohingya still taboo in Myanmar

From 1962 to date, the term ‘Rohingya’ is officially or unofficially banned in Myanmar by the military-led or shadow military government. Since 1948, the year Burma got its independence, untill 1961 the Rohingya Muslims got some citizenship rights and the term ‘Rohingya’ and their ethnic identity was also accepted (Ullah, 2016). In 1962 when the military took power, with the discriminatory policies of the Janta government the Rohingya community started to lose all human rights. And since 1982 with the enactment of the apartheid like Citizenship Act, Rohingyas have had to grapple with difficult situations regarding citizenship papers and cards and have truly become stateless within their state (Brinham, 2019).

In 2016 when the quasi-civilian government came to power in Myanmar led by Aung San Suu Kyi there was a hope that the Rohingya people would get their rights. But after just two

months of the installation of the government headed by Suu Kyi, Myanmar authorities first announced their Orwellian ban on the word ‘Rohingya’ in June 2016 (RSF, 2018). During the term of Suu Kyi, the highest ever violence or genocide against Rohingyas occurred in 2017, expelling almost 90% Rohingyas from Myanmar (Myint, 2018; Olney et al., 2020).

On 1st February 2021 Myanmar Army again took power in Myanmar. The position of the current military government of Myanmar is the same as that of the previous junta governments on the issue of Rohingya ethnicity or the term ‘Rohingya.’ In the latest move on 07 January 2022 the military junta appointed Ministry of Foreign Affairs of Myanmar mentioned, “the term ‘Rohingya’ has always been rejected by the Burmese people and is not recognized by the Burmese people” (RFA, 2022). The junta-led Myanmar Foreign ministry gave the statement protesting the IOM activity on the establishment of Rohingya Cultural Memory Centre (RCMC) website (https://rohingyaculturalmemorycentre.iom.int/). The IOM and the Rohingya community living at the camps of Bangladesh jointly launched the website in May 2021 to store the culture and traditions of Rohingya (Sakib, 2021).

Term Rohingya accepted by NUG, Myanmar

After the latest coup by the Myanmar Army, known as the Tatmadaw, in February 2021, there has been massive protest in Myanmar and till today more than 1500 civilians have been killed by the Myanmar Army (Reuters, 2022a). To resist the military junta, former lawmakers and activists of Myanmar formed a shadow government known as NUG (National Unity Government) in April 2021 and NUG showed a positive sentiment recognizing discrimination and human rights abuses against minority Rohingya through a statement

(Torelli & Griffith, 2022). This is the first time since 1962 that any political party or politician of Myanmar has recognized the ethnicity or the term 'Rohingya.'

In addition, many people in Myanmar have started to show some sympathy towards the Rohingya people as they have seen that the Myanmar military's brutalities are not limited to the Rohingya only, rather extended to the protesters and other civilians of Myanmar (Sharma, 2021). Many anti-military protesters of Myanmar expressed regret over not acting in the wake of the 2017 Rohingya crisis when about one million Rohingya had fled the country. Protesters of Myanmar commonly mentioned against the military junta as (Hölzl, 2021):

> First, they (Army) came for the Karen, and we didn't speak out. Then they came for the Rohingya, and we didn't speak out. Now they are coming for ALL OF US.

Voice of Rohingyas

The Rohingya people living throughout the world are very proud to identify themselves as Rohingya. As a researcher the author has interviewed more than 50 Rohingyas living in refugee camps of Cox's Bazar, Bangladesh and more than 50 Rohingyas living in Aotearoa New Zealand (who came to New Zealand from Malaysia through a third country resettlement process) using the Culture-Centered Approach (CCA). The CCA is a meta-theoretical framework developed by Prof. Mohan Dutta that works through structure, culture and agency and it believes communities are their own best problem-solvers (Dutta, 2008).

Among the more than 100 Rohingya participants living in Bangladesh and New Zealand, all of them mentioned that they are 'Rohingya,' and their ancestors were Muslims who lived in

Rakhine state of Myanmar for centuries. One of the Rohingya participant (36-year-old male) living in New Zealand cited that his city name is ‘Rohang,’ and he mentioned:

> We all know that the name Rohingya comes from the word Rohang. The name of the city where I lived before leaving Myanmar is the Rohang city and it is an ancient city of Arakan (Rakhine). Many people believe that the term Rohingya comes from the word ‘Rohang.’

Now more than 1.3 million Rohingyas living in Cox’s Bazar area of Bangladesh and the majority of them are staying in the 33 refugee camps. The refugee people who are staying in the camps mentioned that they are Rohingyas, and the Myanmar authority intentionally labels them as ‘Bengalis.’ They are also realistic to return to Myanmar if their ‘Rohingya’ identity is ensured with the citizenship rights. One Rohingya female (58-year-old) mentioned:

> We are Rohingya. You should also call us Rohingya. We want to live as Rohingya, we want to go back to our country, we want to move freely in our country, the rights the Maugh (Buddhist) people are enjoying, we want the same type of rights in Myanmar.

Conclusion

So, it is obvious that there is an ethnic group named ‘Rohingya’ who once were the citizens of Myanmar but now stateless. The term ‘Rohingya’ is now accepted worldwide as the world witnessed their presence and misery and it is taboo in Myanmar as the state through its discriminatory policies does not recognise them as citizens though they lived there for centuries. However, the future of the ethnic community is still as dark as was before. More than 90% of Rohingyas once living in Myanmar have been expelled by the brutal tactics of

the state or specifically by the Myanmar Army 'Tatmadaw.' Though the Tatmadaw's wish to ban the term 'Rohingya' is not fulfilled as the term is accepted globally, but more than 1.6 million Rohingyas living in Bangladesh do not see any hope for a better future, as after six years of 2017 largest exodus, they do not see any ray of hope to return to Myanmar.

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2.3 Historical background of Rohingyas in Myanmar

Rohingyas have been living for centuries in Myanmar, a South-East Asian country sharing borders with Bangladesh, India, China, Laos and Thailand (ADBI, 2014; Htun et al., 2011) (see Map 1: Locations of Myanmar). Most of the Rohingyas once lived in the Rakhine state that has a long stretch of coastline along the Bay of Bengal (Abrar, 1994; Rahman, 2023b). Rakhine is one of the poorest of Myanmar's seven states (Burke, 2016; Smith, 2019); it is a geographically isolated state in the Western part of Myanmar as it is divided from the rest of Burma by the Yoma or Arakan Mountain range (Roy Chowdhury, 2020). The northern tip of Rakhine state adjoins Bangladesh and there is 270 kilometres of common border between Bangladesh and Myanmar (Hossain, 2000; Farzana, 2016). Although there are some land boundaries between the two countries, the Naf River separates the Rakhine state from Bangladesh (Abrar, 1994; Prodip, 2017; Smith, 2019).

Map 1: Locations of Myanmar (Rakhine state) and its surrounding countries

Source: https://junior.scholastic.com/issues/2017-18/010818/the-plight-of-the-rohingya.html#1090L

2.3.1 Arakan (Rakhine) state – Home of Rohingyas

The words “Rohingya” and “Rakhine” are complementary terms. The term “Rohingya” originated from “Rohang”, which is one of the old names of the Rakhine State (Ullah, 2016). Rakhine was a sovereign and independent state until 1784, when it was known as the “Arakan region” or “Arakan province” or “Kingdom of Arakan” or “Mrauk U.” In 1784, Burma invaded and annexed Arakan (Mrauk-U). Subsequently, it became one of Myanmar’s seven states. According to the 2014 population census, the total area of Rakhine is 36,752 square kilometres and population 3,188,807 (DoP, 2015). However, as mentioned earlier, the Rohingya population was not enumerated in this 2014 census. Unofficial sources estimated that, in 2014, a total of 1.1 million Rohingya-speaking Muslims lived in the Rakhine state (Mooney, 2014). It is worth mentioning here that, in the 2014 census, the Myanmar authorities counted another Muslim ethnic group, known as Kaman, who also live in Rakhine and speak either the Rakhine or Burmese language (Mohajan, 2018).

In terms of the ancient history of Arakan, some scholars have identified the following timeline (Alam, 1999):

(1) 100-788 A.D. (Some Hindu dynasties),

(2) 788-957 A.D. (Chandra Hindu dynasty),

(3) 957-1430 A.D. (A period of Mongolians, Buddhists and Muslims),

(4) 1430-1784 A.D. (Mrauk-U dynasty)

2.3.2 Islam enters Arakan (Rakhine) state (7th to 8th century)

The contemporary Rohingya people claim that they are the descendants of Muslims living in Arakan since the seventh or eighth century (Yegar, 1972). In the long history of Arakan, the indigenous inhabitants have mixed with the Aryans, Mongols, Thais, Mons, Tibetans, Burmese, British, Arabs, Mughals, Bengalees and other races (Sraman, 2006). The majority of scholars believe that Islam was brought into Arakan by Arab sailors in seventh or eighth century (Islam, 2012). Before the entrance of Islam, Arakan was a majority Hindu Kingdom with some Buddhist inhabitants (Alam, 1999; Bahar, 2010; Charney, 2005). Arabic and Persian sailors created pockets of settlements in the course of their trading activities and interactions with the local populace. Intermarriage and general mingling slowly changed the religion, local customs and culture of the Arakan people and the Islamic rituals started to become prominent (Yegar, 1972; Siddiqui, 2011). Some historians mention that the first Muslims to settle in Arakan were Arabs who came under the leadership of Sayed Mohammad Hanifa, one of the sons of Hazrat Ali, the fourth Caliph of Islam in the late seventh century (C.E.) (Husarski, 2017). Sayed Mohammad Hanifa married the queen Kaiyapuri[2], who had converted to Islam. Since then, Islam has played an important role in Arakan (Kadoe & Husein, 2015). From the 9th to 16th century, an increasing number of Muslim migrants from Afghanistan, Persia, Turkey, northern India, and the Arabian Peninsula arrived and integrated into Arakan society (Mohajan, 2018).

It is fair to say that in different periods, Arakan was ruled by Hindu, Muslim and Burmese kings (Alam, 1999). Islam arrived in greater Bengal in 1203 A.D. Since then, the Islamic influence in Arakan grew over time as the region is proximate with greater Bengal (Bhonsale,

[2] Kaiyapuri, the queen of Cannibals ruled the hilly deep forest of Arakan region and sometimes attacked and looted the people of Arakan. In 680 A.D. after the war of 'Karbala' Mohammed Hanifa with his army arrived at Arab-Shah Para, near Maungdaw of the Northern Arakan and he defeated queen Kaiyapuri and later married her. The peaks where they lived are still known as Hanifa Tonki and Kaiyapui Tonki. (Alam, 1999)

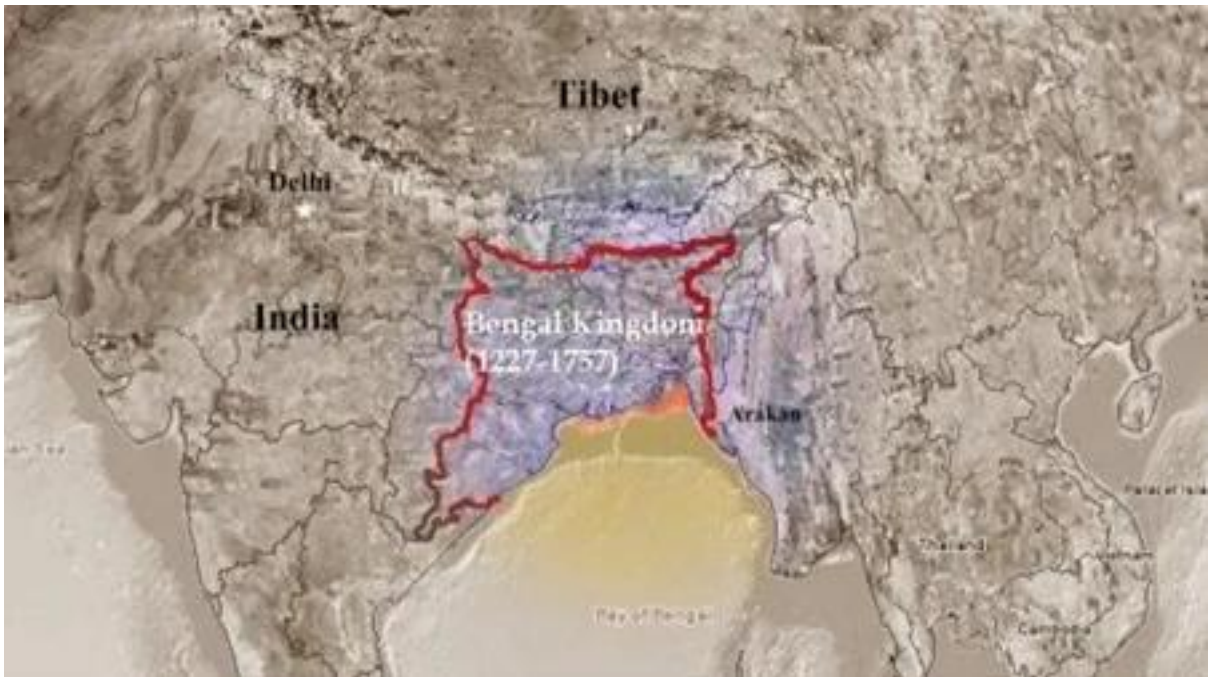
2015; Eaton, 1993). Islamic rule and influence in Arakan lasted for more than 350 years until the Burmese invasion in 1784 A.D. (Al-Faẓl ʻIzzatī et al., 2002; Ba Tha, 1999 as cited in Leider, 2015, p. 23). During this period of Islamic influence, many ethnic groups, namely the Mughals (e.g., with the flight of Mughal prince Shah Shuja in 1660), Turks, Persians, Central Asians, Pathans, and Bengalis, moved into the territory and mixed with the local Arakani people. As discussed earlier, seafaring Arab merchants and Sufis spread Islam in the Arakan region and along the southern coastal areas of Bengal (Eaton, 1993). Numerous Darghas or shrines dotted along the Arakan and current-day Bangladesh coasts testify to the Sufi presence. From 1430 to 1785 A.D., Arakan was like a Sultanate kingdom (Mrauk-U Kingdom) of Bengal or Indian origin with significant Islamic influence (Alam, 1999). Some historians claim that this period was the "golden age of Arakan" (Karim, 2000).

2.3.3 Greater Bengal influence in Rakhine (1430-1785)

Historically, Arakan was always linked to greater Bengal[3] due to its geographical proximity (see Map 2: Bengal Kingdom). It was distant to the other territories of then Burma. In 1404, the Arakan King Narameikhla (Sulaiman Shah or Meng Soamwun) had to flee to Bengal due to Burman invasion and took shelter there for 24 years (Charney, 1998). For his shelter, Narameikhla went to Gaur, then capital of the Bengal Sultanate (from 1352 to 1576 A.D.) (see Map 3: Bengal Sultanate). Arakan became independent from the Mughal Empire some 86 years earlier.

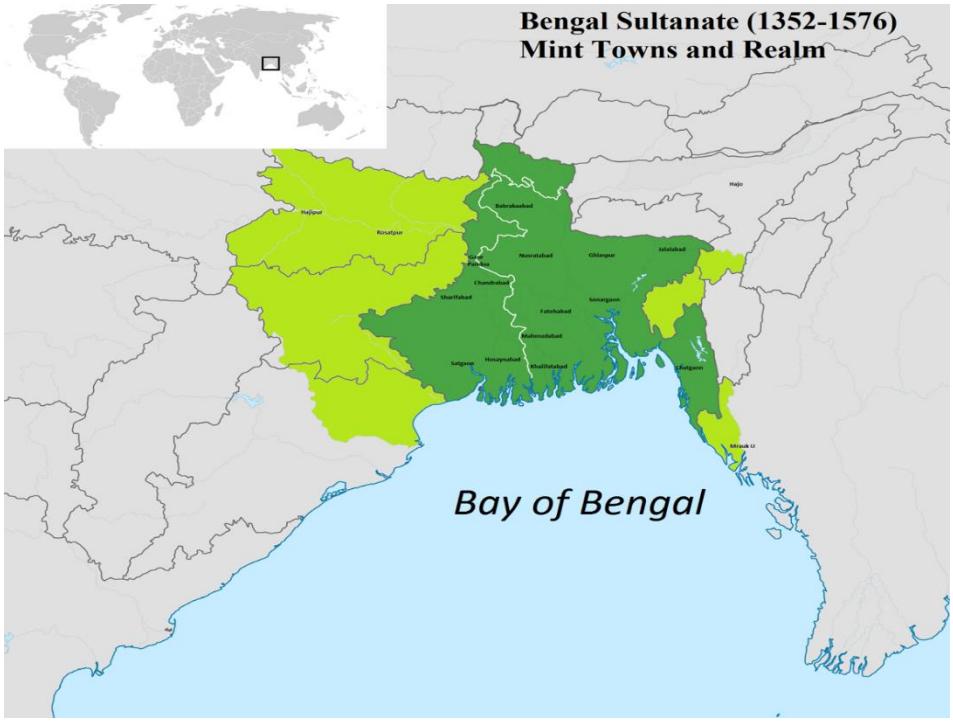
[3] Greater Bengal comprises of Bangladesh, West Bengal (India), parts of Tripura (India) and Assam (India). The language of greater Bengal is Bengali or Bangla, which is the 6th most spoken in the world (Sarkar, 2012). On August 17, 1947, the Redcliff borderline had divided greater India into three parts: West Pakistan (present-day Pakistan), India (present-day India) and East Pakistan (present-day Bangladesh) (Singh, 2020).

Map 2: Bengal Kingdom (1227-1757)



Source: https://images.saymedia-content.com/.image/c_limit%2Ccs_srgb%2Cq_auto:eco%2Cw_520/MTc2MjY0MjMyMTUyNjA1ODY5/ancient-structures-of-bengal-in-pictures.webp.

Map 3: Bengal Sultanate (1352-1576)

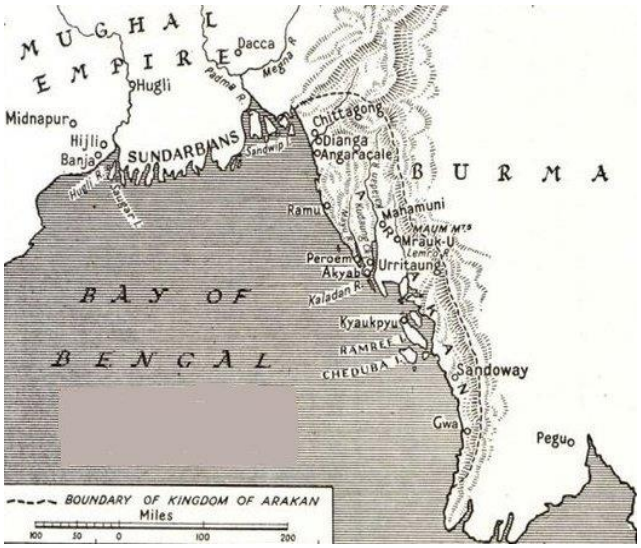


Source: https://discover.hubpages.com/education/ancient-structures-of-Bengal-in-pictures.

However, the then Sultan of Gaur (Sultan Ahmad Shah or Giasuddin Azam Shah), welcomed the Arakan king, Narameikhla who remained at the court of Gaur, served as an officer in the Bengal Sultanate army, and fought in wars (Phayre, 1883). In 1430, Narameikhla got support from the Bengal Sultanate to regain his throne (Chan, 2012). Upon his conquer of Arakan, Naramiekhla left the then Arakan capital city Laungyet (1237-1430) and founded a new capital city, Mrohaung or Mrauk-U (1430-1785), which remained the capital of Arakan for the next four centuries (Akhtaruzzaman, 2000).

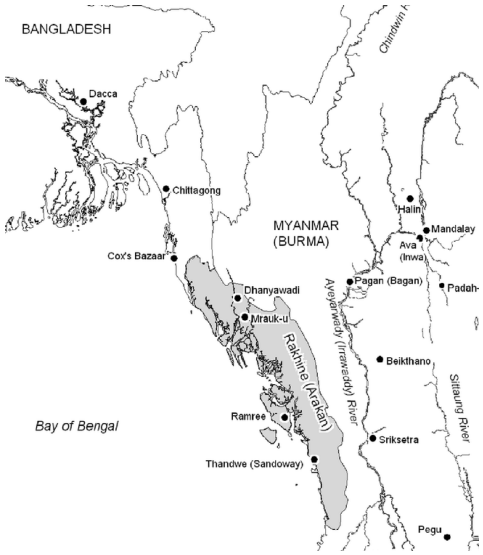
Based on the capital Mrauk-U, the kingdom was established near the eastern coast of the Bay of Bengal. The Mrauk-U kingdom ruled over the Arakan and Chittagong area of then Bengal (see Map 4: Kingdom of Mrauk U). The present-day Rakhine state is the kingdom of Mrauk-U except the Chittagong region that now belongs to Bangladesh (see Map 5: Present Rakhine state of Myanmar).

Map 4: Kingdom of Mrauk U (1430-1785)



Source: http://www.rna-press.com/en/documents/19886.html

Map 5: Present Rakhine state of Myanmar



Source: https://www.researchgate.net/figure/Rakhine-Arakan-State-Myanmar-in-regional-context_fig1_242159032

Mrauk-U went on to conquer the Chittagong area in 1582, but the area again came under Bengal control in 1666 (Yimprasert, 2004; Yunus, 1994). The Muslim soldiers who came with Naramiekhla from Bengal to regain the Arakan throne settled around Mrauk-U (Bhonsale, 2015). Some scholars also mentioned that the soldiers were Muslims or Rohingyas who helped Naramiekhla to regain his throne (Forster, 2011). As Naramiekhla regained his throne with help of the Bengal Sultanate, he agreed to pay tribute to Bengal. Naramiekhla agreed to pay one lakh (100,000) tanka[4] per year to the Bengal Sultanate (Paton, 1828; Stephen, 2008). The Rohingya people also claim their presence in modern-day Burma (Myanmar), which dates back to the times of the Kingdom of Mrauk U (Berlie, 2008). The present-day Rakhine State consists of five districts and 17 townships; Mrauk U is one of the districts and a township of Rakhine state (Amnesty International, 2017).

During the Mrauk-U Sultanate, a close cultural contact between Arakan and Bengal was established. Starting from the king Naramiekhla's rule, this close contact continued until the end of the Mrauk-U dynasty in 1785. Although Naramiekhla and other Mrauk-U kings were Buddhist, they adopted some Islamic rituals, such as the maintaining of silver coins that bore Muslim titles (Kalima- the Muslim declaration of faith) in Persian. Occasionally, the kings appeared in Muslim costumes in the style of the Sultan of Bengal and took Muslim names (Forster, 2011; Chan, 2012). For example, Naramiekhla took the name Sulaiman Shah, Min Khari was known as Ali Shah or Ali Khan, and Thiri Thudhamma as Salim Shah.

The cultivation of Bengali literature was advanced in Arakan when Chittagong was annexed into the Mrauk-U kingdom. Most of the Bengali Muslim poets got high civil and military positions during the Mrauk-U dynasty and cultivated Bengali literature (d'Hubert, 2014).

[4]Taka is the name of the currency of Bangladesh. The word 'Taka' derives from the Sanskrit word 'Tanka' which was a denomination of silver coin of four Masha (1 Masha = 0.972 grams) weight in ancient, and medieval times. (https://en.banglapedia.org/index.php/Taka).

Among them, Daulat Qazi and Syed Alaol became very famous. They worked as court poets of Arakan and greatly contributed to the development of Bengali literature. Daulat Qazi (1600-1638), the medieval Bengali poet, was appointed as a court poet of King Thiri ThuDhamma (Salim Shah), for whom he composed the poem Satimayna O Lorchandrani (সতীময়না ও লোরচন্দ্রানী). He was able to complete only two-thirds of the poem before he died, and the rest was completed by poet Alaol. Syed Alaol (1607-1680) was one of the greatest poets of medieval Bengali literature. His most significant contributions to Bengali literature were translations of some great works from different languages into Bangla. Alaol is well known for his masterpiece, Padmavati (পদ্মাবতী), which depicts the story of Padmavati, the Sinhalese princess. It is the translation of a Hindi poem "Padmavat" by Malik Mohammad Jayasi. Alaol Hall, a student dormitory of the University of Chittagong and Alaol Sahitya Puroshkar (আলাওল সাহিত্য পুরস্কার), a Bangladeshi literary prize, are testament to this great poet's influence on present-day Bangladesh and recognition of his contributions to Bengali literature.

During the Mrauk-U dynasty, Portuguese seafaring traders came to Arakan in the 15th century for doing business (Yimprasert, 2004). With the help of Arakan Buddhists (Maughs), the Portuguese traders got engaged in the slave trade and sold Bengali Muslims and Hindus as slaves in Arakan (Harvey, 2019; Minar & Halim, 2020). The anarchy created by Maughs (Rakhine Buddhists) in Cox's Bazar, Chittagong, and Sundarbans area during the 17th and 18th centuries gave birth to the Bengali proverb of "Mogher Mulluk" (মগের মুল্লুক), meaning the age of Arakanese anarchy (Chan, 2012; Mahtab, 2017). This phrase is still in active use in the Bengali language to mean extreme anarchy.

2.3.4 Arakan under the Konbaung Dynasty (1785-1819)

In 1785, the Burmese king Boddawphaya conquered Arakan and expelled some 35,000 Muslims who fled into Bengal, then a part of the British Raj in India (Chatterji, 2017; Minar. & Halim, 2020). This is perhaps the first exodus of the Rohingyas towards Bengal in the modern sense. Due to the cultural differences between Bamar and Arakan, some Arakan (Rakhine) Buddhists or Maughs had also fled at that time and settled in various parts of Bengal, such as Cox's Bazar, Chittagong[5] (now Chattogram) and Patuakhali district of Bangladesh (Banglapedia, 2021). Boddawphaya is called the harbinger for destroying everything Islamic in Arakan and sowing the seeds of distrust between the two communities, i.e., Arakan Muslims or Rohingyas and Rakhine Buddhists or Maughs (Kunnawut, 2018). This distrust continues even today in the Arakan state. In 1824, Arakan was taken by the British and administered as an annexed state of India by the then East India Company.

2.3.5 Colonial era (1824-1948)

Many scholars believe that the persecution of Rohingyas has its root in the institutions, rhetoric, and ethnologies introduced by the British colonial rulers in Myanmar (Myint, 2018; Blakemore, 2019). Although in 1785, some Muslims were expelled from Arakan, the British colonial administration encouraged thousands of Bengalis and Indians to move to the depopulated area of Arakan and settle. Most of these settlers came from the Chittagong area (Chan, 2005; Leider, 2020b). During or before the colonial period, there were no restrictions of movement between Arakan and the greater Bengal area. Since 1885, when Britain annexed the whole of Burma and governed it as a province of the British India, the migration of

[5] The present name of Chittagong is "Chattogram". The Bangladesh government has changed the name effective from September 10, 2018 (Sarkar, 2018). In this thesis, Chittagong and Chattogram are interchangeably used.

Bengalis or Indians to Arakan occurred as a domestic movement instead of a cross-border movement (Tonkin, 2019). At that time, many Bengali/Indian Muslims migrated to Arakan from Chittagong due to higher wages and better living standards. According to the census records, between 1871 to 1911, the Muslim population in Arakan tripled (Chan, 2005). The sudden influx of immigrants from Bengal (i.e., British India) sparked a strong reaction from the local community comprised of mostly Buddhist Rakhine (Maughs) people living in Arakan and sowed the seeds of ethnic tension.

Before annexing Burma (Myanmar) in 1824, the British East India Company entered Indian politics following the defeat of the last independent Nawab of Bengal Siraj-ud-Daula at the Battle of Plassey[6] in 1757 (Belmekki, 2007). This development had transformed the East India Company, a commercial trading venture, into a political entity which virtually ruled greater India for long (Roy, 2014). In 1790, the British authorities assigned Captain Hiram Cox to settle the conflict between Arakan Muslims and Rakhines (Maughs) by rehabilitating the refugees displaced due to Boddawphaya's invasion of Arakan in 1784-85 (Falguni, 2010). Hiram Cox succeeded in rehabilitating some refugees, but his premature death in 1799 put a halt to his work (Ramachandra, 1981). The southern Bangladeshi district town Cox's Bazar is named after Captain Cox. Thus, it is perhaps symbolic that most of the Rohingya refugees who were displaced in the latest wave of events are currently living in camps near the Cox's Bazar area.

During the Second World War, Britain abandoned Arakan in 1942 in the face of Japanese expansion into Southeast Asia (Leider, 2020b). In the chaos of Britain's withdrawal, both Arakanese Muslims (Rohingyas) and Buddhist (Maughs) tried to inflict massacres on one

[6] Plassey (or Palashi) is a small village of West Bengal, situated 150km north of Calcutta (Kolkata) on the banks of the Bhagirathi. On June 23, 1757, the 'Battle of Plassey' took place where the British under Robert Clive defeated the forces of Nawab Suraj-ud-Daula owing to betrayal of several Nawab's generals (Chatterjee, 2023).

another at the instigation of third parties, most notably the British Raj (Leider, 2017). Following the Japanese invasion of Myanmar, Arakanese Muslims supported the British side as the British promised them a land of their own although this promise was not fulfilled later. The Rakhine Buddhists sided with the Japanese (Abdelkader, 2017) and, with the help of Japanese soldiers, carried out massacres against the Arakan Muslims (Rohingyas) in 1942. These attacks left 100,000 Muslims dead and more than 80,000 expelled from Arakan, who took shelter in the then East Pakistan (present-day Bangladesh) (Leider, 2020c; Ullah & Faisal, 2020). This was the second exodus of Rohingyas towards Bengal before the independence of Bangladesh in 1971.

In 1945, Britain retook Burma from the Japanese occupation with the help of Burmese nationalists led by Aung San (father of Aung San Suu Kyi). However, political opponents assassinated Aung San and six members of his interim government in 1947 (Selth, 1986). The unsettled political environment following the assassination prompted some Rohingya Muslim leaders to try to merge the Muslim-majority areas of Arakan with East Pakistan (HRW, 2000). In the 1940s, just before the partition of India, a delegation of Rohingya Muslim leaders met with Pakistan Movement leader Muhammad Ali Jinnah to convince him about the proposal, but their move failed (Fair, 2018). This move backfired politically and instigated the seeds of doubt in Bamar[7] leaders about the patriotic commitment of Rohingyas towards Myanmar (Farzana, 2016). In 1948, Burma gained its independent from Britain with U Nu as the Prime Minister.

[7] Bamar (also known as Burmans) are the largest ethnic and linguistic group in present-day Myanmar. The Bamar comprise roughly 68% of Myanmar's population and have dominated politics and the military since the country's independence in 1948 (Fishbein & Hlaing, 2021).

2.3.6 Burma, Constitutional period (1948-1962)

Following independence, Myanmar enacted the Union Citizenship Act (1948) to recognise all citizens as equal and all persons born in Burma as citizens, provided one parent was Burmese (Htun, 2019). In the 1948 elections in independent Burma, four Muslim leaders (Rohingyas) from Buthidaung and Maungdaw townships became members of parliament (Chan, 2005). Burmese first Prime Minister U Nu proclaimed Rohingyas to be equal to other ethnic groups in Arakan on several occasions. In 1961, the U Nu administration established a Muslim-dominated Mayu Frontier Administration in Arakan. The Prime Minister declared that the inhabitants of the Mayu Frontier belonged to the Rohingya ethnic group (Leider, 2018; Ullah & Chattoraj, 2018). Rohingyas were also included in the 1961 census of Burma as an ethnic group of Arakan (Ibrahim, 2016) and received National Identification Cards with access to all benefits of citizenship (Zarni, 2012). These developments clearly demonstrate that the Burmese constitutional government (1948–1962) recognised the Rohingyas as citizens, who also served as the country's members of parliament (Poling, 2014).

2.3.7 Burma (Myanmar), Military rule (1962-2015)

As stated earlier, the fate of the Rohingyas continued to worsen after the military takeover of 1962. The 1974 Burmese Constitution, which had been adopted based on a socialist manifesto of the military-led government, listed 135 "national races" but excluded Rohingyas (Cheesman, 2017; Smith, 1994). Eight years later, the citizenship law of 1982, which recognised only the children of national races as full citizens, excluded Rohingyas from their citizenship rights and rendered them stateless (Arraiza & Vonk, 2017; Zawacki, 2013). In 1974 the military-led government changed the name of Arakan to Rakhine and in 1989, the

same Government changed the country name to Myanmar from Burma. This change of name as Rakhine state put pressure on the Rohingya Muslims as their rival ethnic group is historically known as the “Rakhine” Buddhists (Albert & Maizland 2020; Hein, 2018).

Since the early 1990s, the movement of Rohingya Muslims has been strictly controlled and their properties have been confiscated by the State (Lowenstein, 2015). In the late 1990s, a local order was issued for the Rohingya Muslims requiring couples planning to marry to obtain official permission from the local authorities (Lewa, 2009). Married Rohingyas are also limited to having two children per couple whereas the Burmese couples have an average of 4.7 children per marriage (HRW, 2013; Kashyap, 2013). Since 2005, Rohingyas in Rakhine State are required to obtain formal permission to travel outside of their villages. Until 2010, the Rohingya Muslims of Rakhine had voting rights in all elections held in Myanmar. However, from 2015 onwards, the Rohingyas have not been allowed to exercise their voting rights (Ranjan & Kaveri, 2020; Tay et al., 2018).

Thus, the Myanmar military government made the Rohingyas stateless; they not only took away their voting rights, but also restricted their freedom of movement. During the last six decades of military rule in Myanmar (since 1962), the Rohingyas have been systematically deprived of all their rights including human, social, political, and constitutional rights. They have become homeless and stateless. Tatmadaw, or the armed forces of Myanmar, has committed, and continues to commit, extensive atrocities against the Rohingya Muslims, including murder, rape, and arson attack. According to some observers, the Tatmadaw used rape as a weapon of war against Rohingyas (Hernandez, 2019; Perria, 2017; Selth, 2018). The observers believe that the long-term goal of the armed forces is to expel all the Rohingyas

from Rakhine (Jennings, 2021; Selth, 2018). They have already successfully expelled 90% of the Rohingyas from Myanmar (Ibrahim, 2018; Wells, 2019).

2.3.8 Myanmar, Suu Kyi Govt. (2016-2021)

Once seen as a beacon for human rights, Aung San Suu Kyi, a Nobel Peace Prize laureate, came to power in 2016. At that time, many observers thought that Suu Kyi would work to solve the ethnic problems including the Rohingya crisis in Myanmar (Barany, 2018). However, Suu Kyi did nothing for, or in fact, committed wrongdoings against the Rohingyas. In June 2016, merely two months after the official inauguration, her government formally banned the use of the word 'Rohingya' (Oruç, 2021; Slodkowski, 2016). Under her watch, Tatmadaw, the country's armed forces, carried out the brutal ethnic cleansing and genocide against the Rohingyas in 2017. This crackdown left an estimated 25,000 Rohingyas dead, 19,000 women and adolescent girls raped, and more than 700,000 fled to neighbouring Bangladesh (Habib et al., 2018; Uddin, 2022). Suu Kyi was silent on the Rohingya genocide issue and always defended the Myanmar Army (Ibrahim, 2019; Strangio, 2017). Quite infamously, she did so in her speech at the International Court of Justice (ICJ) on December 11, 2019 (Beech, 2020). Some observers believe that Suu Kyi herself is a party to the mission of expelling Rohingyas from Myanmar (Hasan, 2017; Zahed & Jenkins, 2022).

2.3.9 Myanmar, Army Govt. (2021-till date)

By the time the Myanmar Army – or Tatmadaw – seized state power on February 1, 2021, more than 90% of Rohingyas had been forced out of Myanmar. The expelled Rohingyas have

been languishing in various refugee camps around the world including Bangladesh. As stated earlier, only a fraction of the total Rohingya population remain in the Rakhine state. However, the army-led administration continues to maintain the same stance towards the Rohingyas as that of all previous army-led governments. Meanwhile, the stateless Rohingyas who live in the Rakhine villages and Internally Displaced Persons (IDP) camps are constantly subjected to restrictions of movement and deprivation of other rights (Amnesty International, 2023; Win & Brinham, 2022). In fact, those Rohingyas still staying in Myanmar, endure dual pressure from two conflicting armed actors: Tatmadaw on one hand, and the rebel Arakan Army (AA)[8] on the other. According to some sources, the Rakhine State is currently virtually run by the de facto AA civil administration (Avila, 2022; Hlaing, 2022, 2023).

2.4 Rohingya exodus towards Bangladesh

In a contemporary sense, the Rohingyas have been fleeing to Bangladesh since the 1970s to escape state-sponsored systemic persecutions in Myanmar. Since 1962, the Rohingya Muslims have suffered numerous human rights violations, such as mass killings, rape, and torture. These violent attacks have compelled them to flee from their country and to seek refuge in neighbouring Bangladesh. In the years following the 1962 military coup, a small but steady flow of Rohingyas to Bangladesh has continued. On average, an estimated 10,000 Rohingyas fled from Myanmar to Bangladesh every year before the 2017 exodus. In the recent exodus, from 25 August 2017, through early 2018, an estimated 10,000 Rohingyas arrived in a single day (Haar et al., 2019; Selby, 2017). On other occasions, major exoduses occurred in 1977-78, 1991-92, 2012, and 2016 (Acaps, 2017; CHL, 2020). Since Myanmar's

[8] Arakan Army (AA) is a Rakhine Buddhist armed rebel group fighting for self-determination for ethnic minorities in Rakhine state since 2009. In a decade, the AA has become one of the most powerful ethnic armed groups in Myanmar and it controls two-third area of Rakhine state (Hlaing, 2023).

independence in 1948, successive governments have carried out some 15 major armed operations targeting the Rohingyas (Siddiqui, 2006; Selth, 2018). Observers believe that all the armed or ethnic cleansing operations have been performed in different names but with the same intention of driving the Rohingyas out of the country (Mandhana, 2018; Nebehay, 2017; Rana & Riaz, 2022).

2.4.1 Operation Dragon King 1977-78

In 1977-1978, Operation Dragon King, under the military dictator Ne Win, forced more than 250,000 Rohingyas out of Myanmar. This government effort targeted the Rohingyas through a policy of registering citizens and screening out foreigners. Most of the Rohingyas took refuge in Bangladesh (HRW, 2000). In this military campaign, the Rohingya Muslims were forcefully evicted from their properties using widespread brutality (Pandey, 2017). In 1978, the then Bangladesh government established 13 refugee camps in the Cox's Bazar area for the Rohingya refugees and sought assistance from the United Nations (HRW, 2000). Later, a majority of the Rohingyas returned to Myanmar under a repatriation agreement between the two countries but some stayed back in Bangladesh (MSF, 2002; Ahmed, 2012). As Operation Dragon King (officially known as Naga Min) failed to permanently expel the Rohingyas from Myanmar, the country's military authorities adopted a new strategy of depriving the Rohingyas of their citizenship rights by enacting a new citizenship law in 1982 (HRW, 2015). This law made the Rohingyas stateless within their state.

2.4.2 Operation Pyi Thaya (Na Sa Ka) 1991-92

Emboldened by the new piece of legislation, the Myanmar Army launched Operation Pyi Thaya (Operation Clean and Beautiful Nation) in 1991 resulting in a massive flow of more than 270,000 Rohingyas into Bangladesh (Grantee, 2012; Grundy-Warr & Wong, 1997). This time, the operation was carried out by the border guard force Na Sa Ka[9] that was accused of systematic violence and persecutions targeting the Rohingyas (D' Costa, 2012). Following this exodus, a series of negotiations between the two governments over 12 years, resulted in repatriation of most of the Rohingyas from Bangladesh to Myanmar (Cheung, 2012; Ullah, 2011). This time, the Bangladesh authorities erected about 20 camps and, following the repatriation, closed all except two at Nayapara and Kutupalong. These two continue to exist as registered camps (RCs) today (MSF, 2020a).

2.4.3 Communal violence 2012

In 2012, a severe ethnic riot broke out in Rakhine between Rakhine Buddhists and Rohingya Muslims that resulted in more than 140,000 Rohingya people being internally displaced (HRW, 2012). These displaced Rohingyas were put in different IDP camps erected by the Myanmar authorities (Szep & Marshal, 2013). During the 2012 communal violence, many Rohingyas tried to cross the Bangladesh border. However, the Bangladesh authorities did not open its borders this time around; instead, they send back the boatloads of Rohingya refugees to Myanmar (Bashar, 2012; Rahman, 2012). Despite Bangladesh's refusal and sending back

[9] Na Sa Ka (in Burmese Nay-Sat Kut-kwey) was an inter-agency border force comprising of military, police, immigration, and customs officials. Rakhine Buddhists dominated the force, which demonstrated a strong anti-Rohingya agenda. It was established in 1992 with around 1200 officials operating in Northern Rakhine state (Della-Giacoma, 2013). Na Sa Ka was abolished in 2013 and renamed as Border Guard Police (BGP) (Leigh et al., 2022).

of the affected people, many more Rohingyas indeed crossed the border. According to one estimate, more than 100,000 Rohingyas entered Bangladesh following the 2012 communal riot in Rakhine (IRIN, 2014). These Rohingyas could not secure any official recognition from Bangladesh authorities and remained in hiding in the Cox's Bazar area (HRW, 2012). Following this 2012 exodus, one estimate puts the number of documented and undocumented Rohingyas in Bangladesh at more than 400,000 (Bashar, 2012; Al Imran, 2014).

2.4.4 Ethnic cleansing 2016

In October 2016, the Myanmar security forces launched a large-scale operation against the Rohingya Muslims blaming the Arakan Rohingya Salvation Army or ARSA[10] for attacking police posts in Rakhine. The Myanmar army units are accused of killing numerous people, slaughtering children, raping women, burning and looting houses. The United Nations has described the operation as an ethnic cleansing (Aziz, 2020). This operation forced another 80,000 Rohingyas to enter Bangladesh (HRW, 2018). At the beginning of the crackdown in Rakhine, Bangladesh sealed its border. However, the authorities changed the decision on compassionate grounds and opened the border to allow numerous vulnerable and desperate Rohingyas to enter Bangladesh (Radio Free Asia, 2016).

[10] ARSA, formerly known as Harakah al-Yakin, or 'Faith Movement' is a Rohingya insurgent group active in northern Rakhine State who claims to fight for the Rohingya rights (Bhattacharyya, 2021).

2.4.5 Army crackdown leading to genocide 2017

The crackdown against Rohingyas was repeated just the next year in 2016. On August 25, 2017, the Myanmar Army again blamed the ARSA for attacking police posts and started a genocidal crackdown on Rohingyas in Rakhine forcing more than 750,000 Rohingyas to flee their homes (Anwary, 2020; Haar et al., 2019). Numerous news reports blamed local Rakhine Buddhists (Maughs) for aiding the army units in these atrocities. The violence, including killing, reported rape, torture, and arson attack, continued for several months (Messner et al., 2019; Selth, 2018). The United Nations High Commissioner for Human Rights described the 2017 Myanmar military campaign as a 'textbook example of ethnic cleansing' (Rahman & Sakib, 2021). Later, many investigations including a US report confirmed that, in 2017, the Myanmar Army committed 'crimes against humanity,' including genocide against the Rohingya people (Herman, 2022; Khin, 2023).

2.4.6 Exodus results in more Rohingyas than the host community

The exodus of Rohingya Muslims towards Bangladesh started even before Bangladesh's independence from Pakistan in 1971. In 1785, when King Boddawphaya captured Arakan, over two-thirds of the Arakanese population, including Rohingya Muslims and Buddhist Rakhines (Maughs), fled the region and took shelter in various parts of then Bengal (Ahmed, 2019; Chan, 2005). During World War II, the occupying Japanese forces, with the help of Arakan Buddhists (Maughs), tortured and evicted Rohingya Muslims from Arakan, who fled and took shelter in Chittagong and Cox's Bazar areas of then British India (Bahar, 2010; Hoque et al., 2018). Many Rohingyas who fled before the independence of Bangladesh in

1971 never returned to Burma; they became integrated into the local population (HRW, 2000).

The exodus of Rohingyas continued after the independence of Bangladesh, resulting in an increasing number of Rohingyas living in the Cox's Bazar district. Consequently, there are more Rohingyas than host communities in some areas of the district. For example, in Ukhiya and Teknaf upazilas, the current Rohingya population is more than one million whereas the local population is around 0.5 million (Imtiaz, 2018). In effect, the Rohingyas have outnumbered the host communities by two to one in these two upazilas. About 80 per cent of the Rohingya refugees are located in the Ukhiya upazila, causing a four-fold increase in the upazilas's total population (Jerin & Mozumder, 2019).

2.5 Legal status of Rohingyas in Bangladesh

The importance of self-identity is undeniable; losing it, is a painful plight for any individual or community. The Rohingya community has been suffering from this loss of identity for a long time (Burke, 2016; Khuda, 2020). Despite living in Myanmar for centuries, the Rohingyas are deprived of their citizenship rights. For many of them, the experience is equally painful in Bangladesh. Some second or third generations of Rohingyas have been living in this country without even refugee status, let alone any citizenship rights. As stated earlier, the authorities in Bangladesh label the Rohingyas as "forcibly displaced Myanmar nationals" or FDMN, that denies them their refugee status and any associated rights (Yusuf, 2019). As Bangladesh is neither a party to the 1951 Convention Relating to the Status of Refugees nor its 1967 protocol, it does not have any obligation to recognise Rohingyas as refugees (UNHCR, 2007; Zetter & Ruaudel, 2016). Bangladesh's official stance of not

recognising Rohingyas as refugees makes them more vulnerable to deprivation of their basic rights including healthcare (Poël, 2023; Yusuf, 2019).

Until 1992, Bangladesh granted prima facie[11] refugee status through executive orders to the Rohingya people who came as asylum seekers from Myanmar (Mohammad, 2012; Xchange Foundation, 2018; Zetter & Ruaudel 2016). Since 1992 the country has stopped registering Rohingyas as refugees (UNHCR & WFP, 2019) and started to label them as "undocumented Myanmar nationals (UMN)'' or "unregistered refugees'' or "illegal migrants" to Bangladesh (Bashar, 2012; EC report, 2018; UNHCR, 2007). Bangladesh does not have any domestic or national law which covers the issue of refugees or asylum seekers despite the fact that the country has been hosting the Rohingya refugees since its independence (Al Imran & Mian, 2014). In September 2013, the Government of Bangladesh (GoB) has adopted a document titled "National Strategy on Myanmar Refugees and Undocumented Myanmar Nationals" that acknowledges the presence of an estimated 300,000-500,000 "Undocumented Myanmar Nationals" or Rohingya refugees within Bangladesh (Cortinovis & Rorro, 2021). This document also acknowledges to address the humanitarian needs, including limited services (health, sanitation, shelter and education) to the Rohingyas living in Bangladesh (Khan & Rahman, 2020). Thus, regarding the identity status, the Bangladesh authorities referred to the Rohingyas as "UMN" before the 2017 exodus. However, after 2017, they have been using the term "FDMN" but not "refugees". Without the formal "refugee" status, the entire Rohingya population has been deprived of any official protection in Bangladesh.

Due to the lack of a national legal framework on the protection of refugees in Bangladesh, the old law titled "The Foreigners Act, 1946" remains the key legislation governing the status of

[11] Prima facie refugee status is commonly used to grant refugee status by a state or UNHCR if "delegated by the state" on the basis of the readily apparent, objective circumstances in the country of origin giving rise to exodus (Rutinwa, 2002).

foreigners or refugees in the country (Khan & Rahman, 2020). Under this 1946 legislation, Bangladesh prohibits illegal entry of foreigners into the country and makes it punishable with the detention of up to five years. As a result, the Rohingyas, especially women and girls, are often unable to access legal remedies for fear of being arrested or deported under the Foreigners Act, 1946 (Khan & Rahman, 2020). Bangladesh has not enacted any laws or regulations that provide for a restriction to the freedom of movement of Rohingya refugees, but they are confined to the camps and their freedom of movement is strictly regulated under the Foreigners Act, 1946 (a British Indian law) (Azad, 2017; Cortinovis & Rorro, 2021).

Rohingya children born in Bangladesh start life in a legal limbo, as they are not considered Bangladeshi or Burmese by birth as neither country is taking responsibility for the Rohingyas (Strochlic, 2019). Again, the Rohingya refugees are not legally allowed to marry a Bangladeshi citizen. Initially in 2002 a Bangladesh government circular stipulated that a marriage between a refugee and a Bangladeshi citizen cannot be registered mainly to prevent the Rohingyas from seeking a back door to get Bangladeshi citizenship through marriage (UNHCR, 2019b). Two subsequent circulars, published in 2014 and 2017 respectively, further undermined the right to marry for both citizens and refugees by directing Marriage Registrars not to register the marriages of Bangladeshi citizens and Rohingyas (UNHCR, 2019b). In January 2018, the Supreme Court of Bangladesh upheld the ban on marriage between Bangladeshis and Rohingya refugees (Rozario, 2018).

Although Bangladesh is not a party to any refugee-related international treaty or convention, the country has been sheltering Rohingya people for long mainly on humanitarian grounds (Bashar, 2012; Rashid, 2020). On several occasions, the current government of Bangladesh claimed that it had accepted the Rohingya people not out of any legal obligation but under its

prerogative and purely on humanitarian grounds (Khan & Rahman 2020). Bangladesh has expressed sympathy for the plight of the Rohingya refugees and trying to give them shelter, but it has always been reluctant to grant refugee status to Rohingyas. Despite not granting the refugee status, Bangladesh, in the main, respects the principle of non-refoulement which states that when a person leaves their country of origin or nationality, they are not sent back if it is reasonably foreseeable and the country is providing them shelter, freedom of practicing religion and basic healthcare services (Alam, 2020a; HRW, 2018).

In short, it is evident in the above discussion that Bangladesh does not recognise Rohingyas as "refugees"; instead, they call the displaced people as 'FDMN'. The country does not afford them the right to work or freedom of movement and prefers their repatriation to Myanmar.

2.6 Right to access to healthcare of Rohingyas in Bangladesh

As Bangladesh is not a party to important international legal frameworks on refugees and stateless persons, so by law the country is not obliged to provide the Rohingyas with their basic needs (Khan & Rahman, 2020). Bangladesh does not sign 1951 refugee Convention and its 1967 Protocol, and the country does not recognise either the 1954 or 1961 Stateless Persons Conventions (Prodip, 2017). However, the country is a party to various core international human rights treaties, such as the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT); the Convention on the Rights of the Child (CRC); the Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol; and the Convention on the Rights of Migrant Workers and Their Families (CRMW). These

international treaties entail that the state should safeguard the rights including the health rights of Rohingya people while they are sheltered in Bangladesh (Arif, 2020; Gupta et al., 2020; Khan, 2021).

Consequently, while the Rohingyas are not recognised as refugees in Bangladesh, they enjoy basic health rights within the camps (Gupta, et al., 2020). Local and international medical governmental and non-governmental organisations (NGOs) provide basic healthcare services to the Rohingyas living in the camps (Milton et al., 2017; WHO, 2019a). However, the Bangladesh authorities do not encourage Rohingya refugees to formally accessing local public health care systems outside the camps (Gupta et al., 2020; Wali et al., 2018). An exception to this policy was made during the COVID-19 pandemic, when the Rohingya people were given full access to health services with the help of international agencies and were effectively included in the national response plan of Bangladesh including prevention, testing, and treatment (Spoerri et al., 2020; UNHCR, 2020a). In the case of COVID-19 vaccination, the Rohingya refugees living in Cox's Bazar started to receive the COVID -19 vaccines from August 10, 2021 (although the nationwide COVID -19 vaccination program started much earlier on February 7, 2021). By October 2021, 11 per cent of the total population of Bangladesh and 3.7 per cent of the Rohingya refugees in camps had been fully vaccinated against COVID -19 (UNICEF, 2022a). However, by the end of 2022, Bangladesh has achieved its target of 70% of its population including the Rohingyas, fully vaccinated and achieved the herd immunity against COVID-19 (Mary et al., 2023).

The Rohingya refugees are, in the main, confined to the makeshift camps of Cox's Bazar. For their healthcare needs, they are reliant on the health facilities within the camps. In some cases, they have been allowed to go outside of the camps with an official permit, primarily for medical reasons, and to meet a family member in another camp (Wali et al., 2018). In the

case of any emergency health situation, the Rohingya refugees need to seek permission from the camp-in-charge (CIC) – a designated official of the Bangladesh government in charge of each camp – to go outside of the camp with referral from the camp's healthcare facilities (Amnesty International, 2020). However, there is a catch to this condition: although the Rohingya refuges require CIC's permission to go outside of the camps, they are not allowed to directly seek the CIC for an appointment. They are supposed to seek help from the "Majhi" (a Rohingya community leader in every camp) to obtain the CIC permission (Amnesty International, 2020).

In the camps, Rohingyas are the passive recipients of health services targeted through top-down health communication, but they do not need to pay for accessing the visiting doctors. Moreover, often time, they receive free medications form the government and volunteer organisations. There is limited or no information about the true scenario of healthcare services available to the Rohingya refugees living in the camps (Amnesty International, 2020). For years, the Rohingya refugees have been experiencing barriers in accessing and receiving the health care needs in the camps (Alamgir, 2022). Although the Rohingyas are the end-users of any aid or voluntary services arranged for them, their views are not considered in designing or delivering these services. They are totally absent in any decision-making processes (Acaps, 2021). The Rohingya people are not listened to in making any decisions affecting their future, lives, or health. The Rohingya voices have been virtually absent from any high-level discussions (Sullivan, 2020).

Chapter 3: Literature Review

3.1. Refugee health and health communication

By the end of 2022, there were an estimated 35.3 million people who were fleeing persecution, live as refugees in various host countries of the world (IOM, 2023). Within a decade, the number of refugees has more than doubled from 15 million in 2011. Every seven in ten refugees just crossed a single border to reach the neighbouring countries (Anderson, 2023). Low and middle-income countries shoulder the burden of 76% of the world's total refugees; these countries do not have enough resources and financial capability to provide basic needs (Dönmez, 2023; Haider et al., 2022). Thus, the refugee population has become the most vulnerable group in a society with generally poor access to health (WHO, 2023). Although migration and displacement are the key determinants of refugee health today, the dynamics of refugee health remain to be poorly examined globally and the process of health communication between the refugees and the healthcare providers does not receive proper scholarly attention (Sherif et al., 2022). Again, the traditional or Eurocentric health communication models do not generally consider cultures and overlook structures that affect the community agency (Aubel & Chibanda, 2022). Now we will look into some traditional models/approaches of health communication that have been utilised by the health communication experts in the realm of refugee health to be embedded in aspects of culture, structures, agency, power and/or colonialism.

3.2 Theories of refugee health and health communication

Health communication has emerged as a specialised area of social science in the 1970s and 1980s with the central role of human interaction in the provision of healthcare and promotion of health (Arnston, 1985; Berry, 2006; Kreps, 1981, 2012; Malikhao, 2020; Ratzan et al., 1996). In short, health communication can be defined as the branch of communication that relates to health. In a health emergency like a refugee crisis, effective health communication helps to prevent death and improves the health conditions of the vulnerable refugee people. If we think about the refugee health in a camp or settlement, then "the public health response focuses on identifying and addressing life-saving needs" (UNHCR, 2024). Therefore, health communication is vital. Health communication is a multifaceted field involving health centres, health professionals and the mass people (Maldonado et al., 2020). For refugees, the issues of health become complicated considering the constraints of the facilities where they live. However, there are several theories and models of health communication through which interventions can be made for positive changes in a community.

3.2.1 The Health Belief Model

Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviours based on the perceptions or beliefs of individuals. The HBM was developed in the 1950s with the aim of understanding the behavioural changes of individuals (Jones et al., 2015). There are six core constructs of HBM: 1) perceived severity, 2) perceived susceptibility, 3) perceived benefits, 4) perceived barriers, 5) cues to action, and 6) self-efficacy (Chin & Mansori, 2019; Dadipoor et al., 2017; Dehghani Tafti et al., 2018). Researchers argued that HBM can be used to develop strategies to promote healthy

behaviours to make positive changes in the health condition of individuals (Sulat et al., 2018).

Critics argue that the Health Belief Model emphasises mainly on cognitive constructs of individuals, and overlooks social and cultural factors (Alyafei & Easton-Carr, 2024; Daniati et al., 2021). Jones et al. (2015) observe that HBM is less frequently used by the communication scholars as this model has limitations for explanatory frameworks. Herrmann et al. (2018) mentioned that "HBM is more descriptive than explanatory and does not suggest a strategy for changing health-related action" (p. 11).

3.2.2 Theory of reasoned action

The theory of reasoned action is a cognitive theory that aims to explain the relationship between attitudes and behaviours of human beings (Fishbein, 2008). Developed by psychologists Fishbein & Ajzen (1975), the theory of reasoned action (TRA) is used to predict individuals' behaviour based on their pre-existing attitudes and behavioural intentions. TRA has three main constructs: attitude, intention and behaviour (Fishbein & Ajzen, 1975). According to TRA, behaviour is determined by a person's intentions, which, in turn, is influenced by attitudes (Hagger, 2019). TRA believes that an individual's intention determines whether or not a behaviour will take place and intention is composed of attitudes towards behaviour and subjective norms (Fishbein & Ajzen, 1975). Attitude is the way of thinking or feeling and subjective norm refers to the social construct that an individual may be experiencing to perform by their family and friends (Ham et al., 2015).

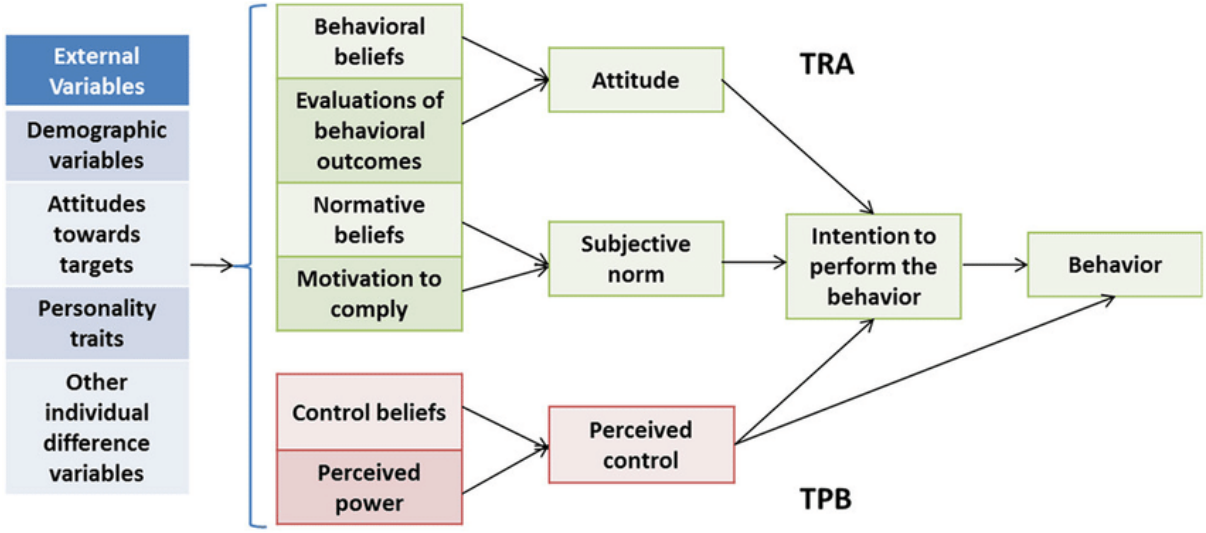
Theory of reasoned action also has some limitations. This theory does not consider the complexity of human behaviour as people do not take decisions based only on their attitudes and subjective norms. The decision-making process has multiple factors, such as the context, the society, past experiences, emotions etc. (Fong & Wyer Jr, 2003; Salehzadeh & Ziaeian, 2024). This theory does not consider the influence of external factors, such as cultural or societal factors although attitudes and subjective norms may vary in different cultural or societal contexts. Kippax & Crawford (1993) observed that TRA has dependency on cognitive structure; it ignores "the connections between individuals, both the interpersonal and social relations in which they act, and the broader social structures that govern social practice" (p. 255). Sheppard et al. (1988) mentioned that the TRA only deals with behaviours but not with the outcome or result of the behaviours.

3.2.3 Theory of planned behaviour

Theory of planned behaviour (TBP) is an extension of the theory of reasoned action. TPB "was developed by Icek Ajzen (1985, 1991) as a general model to predict and explain behavior across a wide range of different types of behaviors" (Kan & Fabrigar, 2017, p.1). According to TRA, attitude and subjective norms lead to shaping intention to perform the behaviour but it does not account for people's perception of power. So, in TBA an additional 'perceived behavioural control' component has been added that results in individuals behavioural control depending on the situation. 'Perceived behavioural control' or 'perceived control' is made up of control beliefs and perceived power (Ajzen, 2020). Here, control beliefs mean beliefs about the presence of factors that may facilitate or impede performance of the behaviour and perceived power mean the beliefs about the power of situational and

internal factors that work to inhibit or facilitate the performing of the behaviour (Ajzen, 2020).

Figure 1: Theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB)



Source: https://www.researchgate.net/figure/The-theory-of-reasoned-action-and-planned-behavior-Revised-from-Health-behavior-and_fig1_308784496

Despite adding some new constructs, the theory of planned behaviour has still attracted some criticisms. One of the main concerns of TPB is that this theory does not allow changes in its construct over time (Hagger & Hamilton, 2024). TPB assumes that attitudes, subjective norms, and perceived behavioural control are stable across different situations and contexts. This assumption may not be true. Individuals' attitudes, norms, and perceived control may vary depending on the context or situations in which the behaviour is shaping through.

Sniehotta et al. (2014) observed that "the static explanatory nature of the TPB does not help to understand the evidenced effects of behaviour on cognitions and future behaviour" (p. 2). Again, the TPB's themes, such as attitudes, subjective norms, and perceived behavioural control, are not universal constructs and may vary across different cultures, which is potentially overlooked in TPB (Trafimow, 2015; Yuriev et al., 2020). Morren and Grinstein (2021) cited that "personal norms play a role in how TPB variables affect behavior, and that this role moderately differs across cultures" (p. 11).

3.3 Theory of development communication comprising CCA

Health communication is a part of development communication (DevCom) and so the theories which were embarked for health communication also talk about the communication for development (C4D). In short, development communication is the art and science of human communication to facilitate social development or to find the ways in which sustainable social change can be achieved. The term "development communication" was first coined in 1972 by Nora C. Quebral, a Filipino academic and pioneer in the field, who is often referred to as the "mother of development communication" (Iroh & Aghamelu, 2024). Nora C. Quebral defines development communication as "the art and science of human communication linked to a society's planned transformation from a state of poverty to one of dynamic socio-economic growth that makes for greater equity and the larger unfolding of individual potential" (Quebral, 2006, p.1).

The concept of development communication emerged in the 1940s and, over a period, transformed from development support communication to more recent Communication for Development (C4D), mainly favoured by UNICEF. Communication for Development (C4D)

gives prioritisation on the communication systems and processes that facilitate marginalised people to speak out on issues important to their health and wellbeing (McCall, 2011). In 2006, the World Congress on Communication for Development defined C4D as "a social process based on dialogue using a broad range of tools and methods. It is also about seeking change at different levels, including listening, building trust, sharing knowledge and skills, building policies, debating and learning for sustained and meaningful change" (UNDP, 2009, p.5). In short, Communication for Development (C4D) enables people, particularly the most marginalised in society, to participate in decision making processes that affect their lives (SDC, 2016; UNDP, 2009).

Although Communication for Development (C4D) is a new concept of development that talks to include the marginalised communities, it has some drawbacks. As the C4D is mainly utilised by UN and its development partners, it always tries to follow the aspirations of donor agencies, not considering the ground level thoughts (Waisbord, 2005). The C4D always follows a top-down approach that builds on Bandura's (2001) social cognitive learning theory that suggests people learn by observing others. Through a top-down approach, the development is planned by the experts at the top. This type of development model has been criticised by Escobar (1995) as he observed that this is nothing but for "making of the Third World." Dutta (2014) criticised this top-down approach of DevCom claiming that it always led to the "denial of the communicative capacity of the margins … in the co-optation of the margins as the subjects of top-down communication" (p. 68).

Other limitations of DevCom (C4D) includes its failure to consider cultural contexts. Malan (1998) cited, "in view of the emphasis on the economic basis of development, it was not

surprising that the role of culture in development was for many years largely ignored" (p. 71). Many development projects have been undertaken utilising the DevCom theory and approaches by ensuring a fixed formula of the implementation process and ignoring cultural contexts. DevCom believes that this process of development can be achieved "through changes in beliefs, attitudes, and behaviors (C-A-B) catalyzed by the diffusion of communication technologies (such as radio, satellite, and television) in undeveloped societies" (Lerner, 1958 as cited in Dutta, 2015, p. 123). However, Vyver & Vyver (2017) criticised that development should not be "a fixed recipe that different cultures can follow…. the recipe must be adjusted for each project and must be unique in order to fulfil the needs of the specific culture" (p. 110).

Considering the early development communication process having its root in colonialism, many scholars (mostly from Global South) proposed to include culture in development projects (Dutta, 2015). Responding to this, international organisations including the UN "started shifting their paradigm toward the incorporation of culture and participatory communication into multicultural participatory development programs" (Dutta, 2015, p. 124). However, this new form of development incorporating culture also follows top-down neoliberal development agendas, erasing the voices of sub-altern communities (Dutta, 2011). In postcolonial studies and critical theory, the term sub-altern designates the people living in the lower social classes as 'margins of the margins". The term 'subaltern' was coined by Antonio Gramsci, an Italian Marxist intellectual, while identifying cultural hegemony that excludes and displaces people by denying their agency and voices in colonial politics (Chaturvedi, 2000; Patnaik, 1988; Smith, 2010). Gayatri Chakravorty Spivak, an Indian scholar and literary theorist, states that "the reasonable and rarefied definition of the word

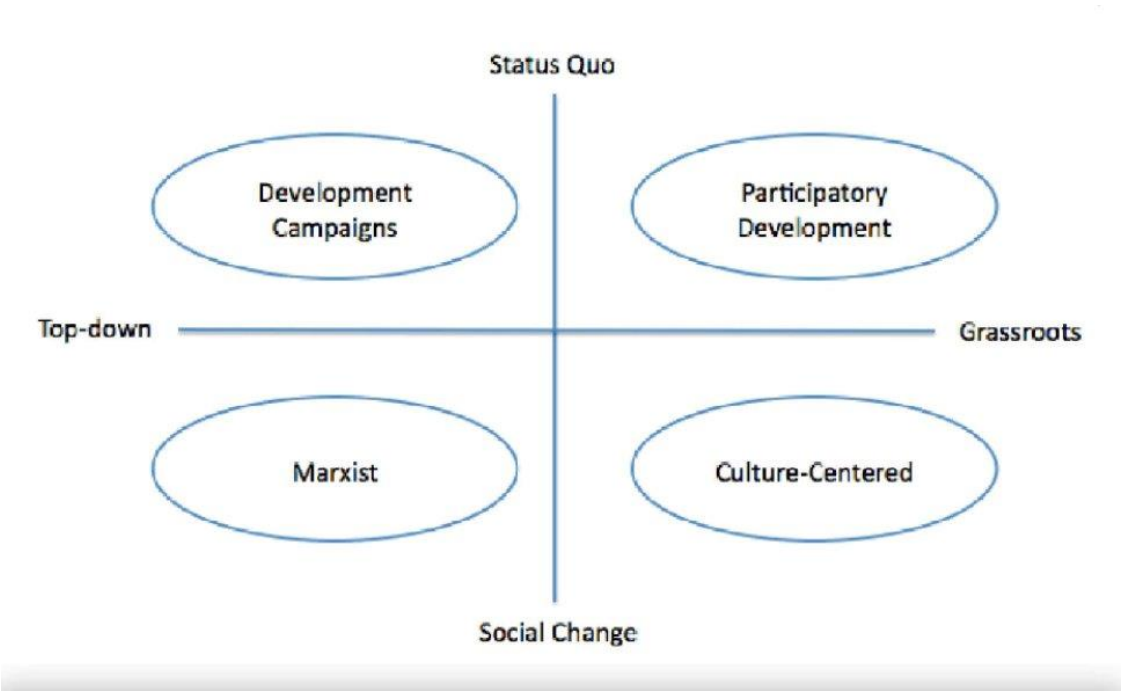
subaltern that interests me is: to be removed from all lines of social mobility" (Spivak, 2005, p. 475).

Any development leads to social change, and development and social change are directly proportional to each other. Various theoretical schools of thoughts have emphasised different aspects of social change. However, one of the most prominent, Marxist theory that talks about the participation of the proletariat (labour class) in revolutionary processes against bourgeoisie (capitalist or ruling class), in turn talks in favour of the neo-liberal capitalist world (Dutta, 2020). "Extensions of a Marxist analysis in the realm of development connect the capitalist formations of global economies to logics of imperialism, fostering the space for the articulation of dependency and world system theories that connect the question of underdevelopment to the prevailing logics of development" (Peet & Hartwick, 2015 as cited in Dutta, 2020, p. 14). Again, Marxist thoughts of development communication "attended to inequalities in the distribution of material resources that produced development and underdevelopment, creating dependencies in the world systems" (Dutta, 2020, p. 372). Again, Marxist development thoughts did not take into account the cultural context as Rummel (1977) observed that the concepts of culture were not considered in any part of Marx's intellectual world and even if there is any consideration of culture that "serve the interests of the ruling class" (Kellner, 2023, p. 1423).

Incorporating the principles of sub-altern studies, reciprocating neoliberal thoughts of development, co-opting culture (centering cultural thoughts), and proposing bottom-up theories, Culture-Centred Approach (CCA), an emerging approach of development communication, has been introduced in the new era of development. Dutta (2008) cites that,

"the culture-centered approach draws much of its theoretical, methodological and application-based focus from critical theory, cultural studies, postcolonial theory and subaltern studies" (p. 8-9). Considering the interactions between status quo and social change, and the top-down versus participatory communication, Dutta (2020) proposes four different types of approaches including Development Campaigns & Marxist theory (based on top-down interventions) and Participatory Development & Culture-Centred Approach (based on grassroots involvements).

Figure 2: A conceptual framework for social change communication (Dutta, 2020)



Source: Communication, Culture and Social Change book, p. 13 (Dutta, 2020)

Culture-Centred Approach builds on the culture, structure and agency tenets "questions the constructions of culture in traditional health communication theories and applications, examines …. the cultural voices of marginalized communities in their constructions of

health" (Dutta, 2008, p. 4). As my PhD thesis is to understand the process of construction of health of Rohingya refugees living in Bangladesh, who are the textbook examples of marginalised or sub-altern communities of the world, I prefer to adopt the Culture-Centred Approach (CCA) for the theoretical and methodological underpinning of the research study.

3.4 Culture-Centred Approach (CCA)

The Culture-Centred Approach (CCA) is a health communication framework that emphasises the need to listen to marginalised and subaltern voices to generate discursive spaces for structural transformation and to create avenues for social change (Basu & Dutta, 2009; Dutta, 2007, 2008). While the traditional Eurocentric (Western) health communication approaches adopt a linear, top-down model to study health disparities and develop health programs and policies, CCA is a bottom-up model, and it privileges local centric articulations of voices (Basu, 2010; Dutta, 2008). CCA involves the voices of locals by engaging them in a dialogic process through working in solidarity with cultural communities. The CCA argues that the localised articulations of health offer frameworks for developing culturally appropriate health policies and programs that seek to eliminate health inequities and improve the proper use of existing resources of health (Dillon & Basu, 2016; Dutta, 2008). The CCA locates health meanings within active, communicative, and participatory processes of individuals that builds upon their sense of cultural frameworks and the existing structures that influence their ability to enact health (Basu, 2010, Dutta, 2008).

The Culture-Centred Approach proposes that cultural contexts are the entry points to theoretical insights into how health decisions and meanings are negotiated in marginalised

communities (such as Rohingya refugees), and therefore offer legitimate theoretical frameworks for developing grass-roots-driven health policies and programs (Dutta, 2008). CCA works through dialogue with the cultural insider so that the local meanings of health can be articulated and understood, by continually negotiating the spaces between local sites and global platforms (Dutta & Pal, 2010). CCA believes in listening to marginalised communities (such as Rohingya refugees) that enables mainstream conceptual frameworks and methodologies to be questioned and to be seen as tainted (Dutta, 2014). "The CCA opens up the definition, meaning, and design of participation to community voices, with the goal of building "theories from below"" (Dutta, 2018, P. 240).

The CCA is founded upon the notion that listening to communities at the "margins of the margins" [12] offers an entry point to addressing the global inequities that are produced by neoliberal globalisation (Dutta, 2011, 2012). Kumar (2020) has mentioned that the primary agenda of the Culture-Centred Approach (CCA) is to engage traditionally silenced voices (e.g., refugee voices) in constructing meaningful and culturally relevant health interventions. Dillard and co-authors (2018) have revealed that CCA provides alternative ways to bridge theoretical approaches by implementing community led participatory research. The research in CCA is underpinned by a fundamental understanding of the key concepts: a) community; b) partnerships; and c) trust. The CCA is then worked through dialogic engagement and mutual respect between academia (researcher) and community partnerships (Dillon & Basu, 2016). In this case, showing solidarity with the community, researchers listen to and document the perspectives of the community's problems. Informed by scholarly conventions, the researchers then introduce these voices into the academic and political discourses where

[12] The term "margins of the margins" has been used in the literature since the end of 20th century but Prof. Mohan Dutta who develops the Culture-Centred Approach (CCA) theory (Dutta, 2008) frequently uses the term 'margins of the margins' as a key concept of CCA. The concept "margins of the margins" reflects the processes of discursive erasure and material marginalisation constituted in community organizing spaces in marginalised contexts (Dutta et al., 2020).

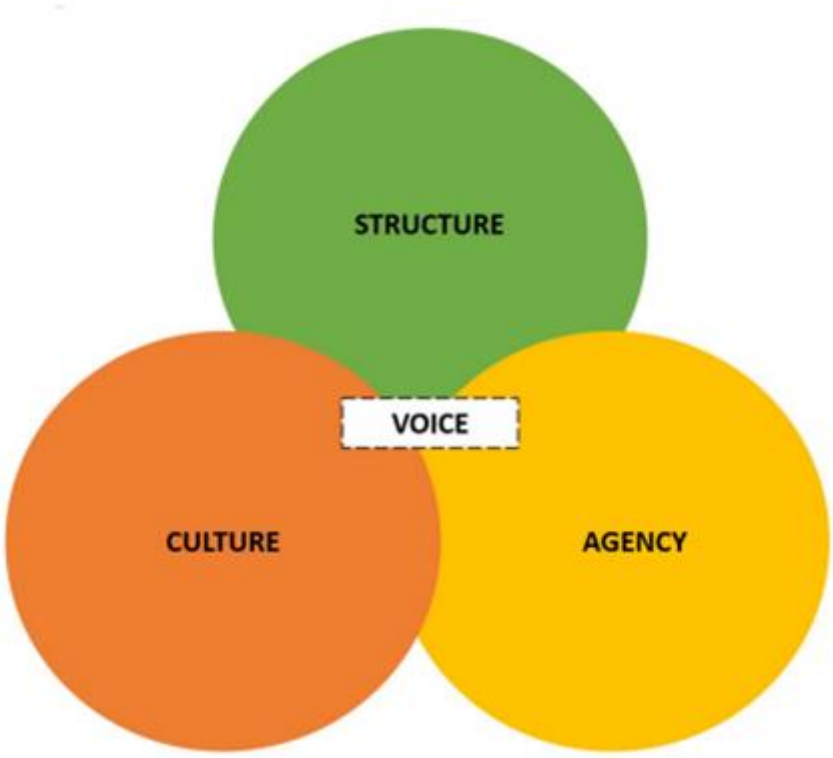
they are often absent (Dutta & Basu, 2011). By this process, the CCA promotes an activist-orientated intent on creating entry points for marginalised communities to share their experiences of health and suffering in a way that works toward meaningful reforms (Dutta, 2008, 2012).

The Culture-Centred Approach works by creating spaces for listening to the voices from the margins by understanding their culture, structure, and agency (Dutta, 2008). The CCA depicts the way that culture, structure, and agency dynamically interact with each other in the realm of health communication (Dutta, 2008) (See Figure 3: Tenets of Culture-Centred Approach). Here agency is communicatively expressed, and the process of communication draws upon cultural meanings, that is located with its relationship to structures (Dutta, 2018). In CCA "culture" means the shared practices, values and beliefs of a community. "Structure" is the infrastructure and systems that constrain and enable the behaviour of an individual or a community and "agency" is the capacity for individuals or communities to define problems and create solutions to various problems like health problems. CCA believes culture is constituted by day-to-day activities of a community and health is constructed within the boundaries of culture (Dutta, 2008).

In addition to its three primary constructs (culture, structure and agency), the CCA framework also incorporates a number of secondary factors – including, for example, voice and dialogue, context and space, values, and criticism – that outline the importance of dialogic co-construction of knowledge with the "margins of the margins" (Sastry et al., 2019). To access and understand communication that emerges from the intersections of culture, structure and agency, Dutta et al. (2016) assert that "the core methodological tool for the CCA is dialogue" (p. 5). This dialogue or voice infrastructure is encountered with specific

techniques including ethnographic observation, focus groups, in-depth interviews, community forums, photovoice, and other practices in which dialogue between researchers and community and between community members and others can be enacted (Bates et al., 2019). By ensuring that communities at the "margins of the margins" are seen as a space for identifying structural challenges and co-creating community-anchored solutions to these challenges, CCA explores the communication processes through which infrastructures for voice can be co-created in communities (Dutta et al., 2020). Koenig et al. (2012) observes that in CCA, structure and agency are intertwined within culture and the interplay of culture, structure, and agency creates spaces for voice of community members to enact positive changes in their lives, especially in marginalised settings.

Figure 3: Tenets of Culture-Centred Approach (Dutta, 2008)



Dutta et al. (2013) have mentioned that research in CCA begins by formulating open-ended questions that are formed by the partnership between the researcher and community. These open-ended questions are the basis of in-depth interviews for identifying key problems for the community, and also create the scope of the solutions to be implemented (Dutta et al. 2013). CCA suggests a shift in the role of the researcher from that of an interventionist who plans and executes campaigns, to that of a listener and a participant, who engages in dialogue with the members of the community (Dutta & Basu, 2007). The members of the community express their problems and proposed solutions, which can be obtained through the interactions between structure and agency that are mediated through cultural processes and practices (Dutta & Dutta, 2013).

3.4.1 Culture

Culture reflects the shared values, practices, and meanings that are negotiated in communities in everyday life (Dutta, 2018). Culture is both static and dynamic; it passes on values within a community, and at the same time co-creates opportunities for transforming these values over time (Dutta, 2018). Culture gets its shape in the community as the members of the community co-construct the meanings of their lives within the local cultural contexts (Brennan et al., 2005; Dutta, 2007; Dutta et al., 2012). Culture was mentioned by Geertz, (1973) as the communicative process by which shared meanings, beliefs, and practices get produced within a community. Culture can be learned, shared, transmitted intergenerationally, and it is reflected in a community's beliefs, values, norms, practices and patterns of health communication (Knibb-Lamouche, 2012; Kreuter & McClure, 2004; Lê, 2006). Culture and its contexts are dynamic and offer theoretical insights into how health decisions and meanings are negotiated by the community members (Dutta, 2008, 2016).

Culture plays a central role in health communication efforts for communities at the margins (such as Rohingya refugees) so that they may be able to articulate and conceptualise the health problems on their own cultural terms (Dutta et al., 2018). Airhihenbuwa and Obregon (2000) have stated that cultural beliefs and, practices should be perceived as strengths, and not barriers to healthy behaviour. The CCA views culture as the filter through which individuals or community construct their health. In CCA, “culture is described as transformative, constantly metamorphosing, and constitutive in the realm of health meanings by the community members" (Dutta & Basnyat, 2008, p. 443). CCA believes that the push for constructing and explaining problems should come from within the culture, representing a community-led approach to solve it (Dutta-Bergman, 2005).

3.4.2 Structure

“Structure refers to the organisation of social systems, the patterns of distribution of resources, and the patterns of control of these resources” (Dutta, 2007, p. 319) in any community. It typically consists of organisations, resources, and networks within and outside the community, and the access to these organisations, resources and networks determine the ways in which community members live (Dutta, 2008). Structures constitutes the communicative rules, logic, and assumptions in a community that enable or constrain access to available resources (Dutta, 2018). This rules, this logic, and these assumptions are constituted within social, political, and economic structures, bound to the flowing pattern of power of a society (Dutta, 2018).

In the realm of health, structure refers to the systems of distribution that allocate health care resources, often unequally due to power disparities in society (Dutta, 2008, 2011). Examples of structure that influence health include available medical services, modes of transportation, communication channels, and health enhancing resources [e.g., food, living conditions, WASH (Water, Sanitation & Hygiene) infrastructure etc.]. Structures may also include avenues of civil society organisations and media platforms, as well as national and international aid partners and health policies (Basu & Dutta, 2008). These structural issues, emerging from local and global political and economic conditions, not only shape the individual's perspectives on health, but also enable or restrict certain health behaviours of marginal groups (Dutta, 2008) like the Rohingya refugee community.

Culture and structure are interlinked as culture shapes structures while structures also shape culture (Dutta, 2007). In CCA, every individual is seen as a part of a cultural system as somebody who always interacts with structure for getting healthcare services (Dutta, 2018). CCA offers structure as a way of understanding how society and its members are organised and how they interact with each other for their health and wellbeing (Ramadurai et al., 2012). CCA works with target communities to develop a full understanding of the structures that dominate their lives, and the lived stories that are created while negotiating the structures (Dutta, 2017). CCA attempts to change social structures responsible for the articulation of health through engaging with dialogue with the target population, creating space for marginalised cultural voices (Dutta, 2007).

3.4.3 Agency

Agency portrays the enactment of everyday choices and decisions by any individual or by all the community members amid structural constraints that reflect the daily negotiation of structures (Dutta, 2018). Agency is expressed in the voices of community members, by speaking about their experiences with health and defining the problems (Dutta, 2015). Cultural members of a community enact agency as they navigate existing social structures to solve health problems and to change the structures that constrain their life experiences (Dutta, 2007). On one hand, agency is expressed through the everyday negotiation of structures and, on the other, it is expressed in the transformative politics of resistance (Pal & Dutta, 2013). Agency is enacted in culture and emerges through individuals' ability to navigate with social structures (Dutta, 2008). Sometimes agency is limited by structures; yet it provides a framework to community members for transforming structures through challenging them (Dagron & Tufte, 2006). The concept of agency is the ability of community members to actively pursue participation in change initiatives, either to challenge or collaborate with existing structures.

Structure is necessary to guide agency, and agency is necessary to allow people to choose which structure to follow and how to meet the opportunities or constraints imposed by structure (Wang, 2008). In CCA, agency works though the ability to challenge the existing structures harming well-being while also working within the structure to find solutions to health problems facing the marginalised community (Dutta, 2008). Agency is a practical component in CCA as it considers the action taken by individual or community members in the process of accessing primary healthcare (Basu & Dutta, 2009). Agency does not mean that people are able simply to speak and act as per their wish, but in CCA, agency is constrained and enabled simultaneously by the cultures in which the community people

reside under the existing structures (Bates et al., 2019). CCA believes that subaltern agency can be developed to transform social structures by giving voices to communities at the margins (Dutta, 2011; Acharya & Dutta, 2012).

3.4.4 Culture of Rohingyas

Drawing from postcolonial theory, subaltern studies and a constitutive view of communication, the Culture-Centred Approach notes the interplay of culture, structure, and agency in everyday life through which health meanings of a community are created (Dutta, 2008, 2011). The Rohingya people belong to a distinct culture, language, and faith and they have their own arts and crafts different from those of other people around the world though they are not free to observe their cultural rituals (Ali, 2021). While living in Myanmar, the Rohingya people have experienced severe restrictions on movement, livelihoods, education, religious life, marriage, reproduction, and access to healthcare services (Riley et al., 2020). In Myanmar they were not allowed to form groups or organisations and were rather bound to live with daily torture and abuse by the military and local Buddhists (Tay et al., 2018). While they stay in Bangladesh, Rohingyas' life is more secure compared to that in Myanmar but still highly restricted in terms of movement, jobs, access to education and healthcare services as they are confined to the refugee camps (MSF, 2021).

3.4.4 (a) Religion

Rohingya understandings of disease and health are intertwined with spirituality and/or religion and other spheres of life, such as economic problems like malnutrition, poverty, and poor living conditions, such as a shortage of WASH facilities, and congested living (Ripoll, 2017). Religion is crucial for the wellbeing of the Rohingya people and a major social organising opinion or cultural factor of the Rohingya community (Ripoll, 2017). However, the humanitarian projects that contribute to the overall development of the refugee camps are designed, developed, and implemented in a modernist manner. In this context, functional modalities, such as cultural identity, religiosity, and privacy concerns, often fail to address many social necessities of the Rohingya refugees (Mim, 2020). Gozdziak and Shandy (2002) put forth the idea of religiosity as an overlooked topic in setting up the refugee humanitarian projects. Therefore, many secular humanitarian projects get challenged, resisted, or even rejected by the Rohingya refugees since these projects fail to address relations with their practising religion (Mim, 2020).

3.4.4 (b) Education

Culture and education are two inseparable parameters as any educational pattern gets its guidance from the cultural shapes of a society and vice versa. Education brings desirable change, through which development is achieved to the cultural values of a society or community (Mathews & Savarimuthu, 2020). However, Rohingyas were denied access to education in Myanmar for decades. In Rakhine state Rohingya children were unable to be admitted to mixed Rakhine-Rohingya or Government owned schools because of a lack of legal documents to prove their citizenship (Rahman et al., 2022). Chris Lewa (2012) observed

that more than 60% of Rohingya children aged between 5 and 17 had never been enrolled in any school. As the Myanmar government denied Rohingyas access to formal education, Rohingya children used to get enrolled in informal educational establishments, such as madrassas [Muslim seminaries] and maktabs [mosque-based Islamic education centres] (Alam & Kamruzzaman, 2020; Farzana, 2017a).

In Myanmar, if a Rohingya child somehow managed to get enrolled in an educational institute, s/he would ultimately be caught by the Myanmar authorities as a result of poor Burmese language skills (Farzana, 2017a). Since the sectarian violence in 2012, no Rohingya student has been able to enrol in the Sittwe University, the only university in Rakhine (Alam & Kamruzzaman, 2020). The authorities even expelled previously enrolled Rohingya students and deployed armed police at the university gate to screen out any darker-skinned Rohingyas from entering the campus (Carroll, 2014). As a consequence, 80% of the Rohingyas in Rakhine State were illiterate in 2017, whereas the literacy rate of the Rakhine Buddhists was 84.7% (Carroll, 2021). Briggs (2017) found that during the latest exodus of Rohingyas from Myanmar to Bangladesh in August 2017, the illiteracy rate among the fleeing population was 80% and 60% of them had never been to school.

In Bangladesh, the authorities do not allow Rohingya children to attend public or private schools outside of the refugee camps. Instead, some international and local NGOs and community organisations provide basic education to them (BROUK, 2018; Hossain, 2023a). In the camps, the authorities strictly prohibit both teaching in Bangla (also known as Bengali) and following the Bangladeshi national curriculum. Rather, Burmese or English language is used to provide education to the Rohingya children (Shohel, 2022). In the camps, the education centres are known as Temporary Learning Centres (TLCs) as the Bangladeshi

authorities see the Rohingya crisis as temporary and expect that the new generations will eventually return to Myanmar (Bakali & Wasty, 2020). Currently, approximately 3,400 TLCs provide basic education to over 400,000 school aged Rohingya children in the Bangladeshi camps (UNICEF, 2022b, 2023b). Education is the foundation of good health as it can impart a knowledge of proper healthcare. Since the Rohingya people have either a low level of education or no schooling at all, their knowledge on health is poor, too. They face difficulties in understanding health information provided by health professionals (Mistry et al., 2021; Teng & Zalilah, 2011).

Education through madrassa

Rohingya health beliefs are shaped by their religious beliefs. Many Rohingyas believe that causes of disease are connected to religious issues (Acaps, 2020b; Islam et al., 2021). Connecting religion and disease is one of the practices the Rohingyas follow to maintain their health in the absence of any formal health intervention (Haider, 2020). Attending to religious needs is as important to the Rohingya people as meeting material needs (Ripoll, 2017). Thus, the Rohingyas are eager to obtain religious education; for this education purpose, they rely on madrassas (religious schools) and mosques (places of prayer for Muslims). For decades, the Rohingyas were denied access to formal education in Myanmar, which also increased their reliance on madrassa education (Ripoll, 2017). The trend of madrassa-based and religiously influenced education is prevalent in the Rohingya culture.

In the Bangladeshi camps, Rohingya children do not have the opportunity to obtain any formal education. This scenario compels them to rely solely on the madrassa system. In other words, Rohingya children are bound to receive some basic religious education through madrassas (Rozario, 2019). Critics have claimed that the educational standards of these

madrassas in Bangladeshi refugee camps are low; there also fears that the students might be politically indoctrinated through these madrassas (Crisis Group, 2019). While the Bangladeshi authorities have recognised traditional madrassa certificates and degrees as equivalent to those of the mainstream education system, i.e., certificates obtained under secular secondary, higher secondary, higher education, and the Bangladesh Madrasah Education Board curricula certificates are equivalent (Carroll, 2021). However, this Bangladeshi madrasa education system is not accessible to the Rohingya refugees of Bangladesh. Instead, the madrasas at the refugee camps can merely offer a basic Islamic teaching, such as reading the Quran, learning how to offer daily prayers, etc. Consequently, the education the Rohingyas receive at these madrassas provide little help for them to cope with their health needs.

3.4.4 (c) Gender norms

Gender norms are integral to understanding the dignity of a Rohingya family. Rohingya communities are highly conservative in their gender norms and practices (UN Women, 2020). In the Rohingya culture, a man is the decision-maker in the family or in the society. It is believed that a woman's honour or dignity depends upon the man's command over her. Women's mobility and interactions with other people are also determined and controlled by the men (Acaps, 2022a; Sanchez Bean, 2021). In other words, men are expected to control women's mobility and behaviour; women are expected to be compliant. Maintaining "purdah" by a woman (the practice of using veils to keep women from being seen by outsiders) is an indicator of individual pride and families' face-saving in the Rohingya community (Ripoll, 2017). As a part of purdah, Rohingya women and girls are expected to stay at home and be close to their family, whereas men and boys are present in the public

sphere (ISCG, 2017). A study of inmates at Cox's Bazar's registered Rohingya refugee camps in 2015 found that 95% of the respondents observed the main role of women was to cook; about 53% of the respondents believed that women should not be allowed to leave the house (Sang, 2018).

At home, Rohingya women generally perform traditional gender roles, such as housework and childcare. When they go out, they must cover their heads and faces using a hijab or headscarf (Ripoll, 2017). In the Rohingya community, this practice is the long-held tradition. However, following their displacement to the Bangladeshi refugee camps, some changes to traditional Rohingya practices can be observed. For example, the Rohingya women who used to spend almost 24 hours a day inside their homes in Myanmar are forced to stand long hours in queues to collect food rations or fetch water (Coyle et al., 2020). These changes to circumstances and consequent shifts in behaviour lead to new and emerging impacts on the lives and health of the Rohingya people (Acaps, 2022a).

3.4.4 (d) Patriarchy

The Rohingya society is a patriarchal one; this patriarchal society favours men and disadvantages women. Men make decisions in the family and community (Bentil & Adu, 2020). Toma and co-authors (2018) have observed that cultural norms of the Rohingyas restrict women and girls' movements; they struggle to get access to resources. When a girl reaches puberty, she loses her right to move freely; she must stay at home almost all the time. Tripura (2022) has claimed that the Rohingya women were not allowed to talk to outsiders without husbands' permission. They were not allowed to go out of their houses alone; they must be accompanied by a male family member. Rohingya men in Myanmar are still the

traditional breadwinners of the family and the Rohingya women are confined to homes to look after the household (Akhter & Kusakabe, 2014; Tripura, 2022).

In the refugee camps of Bangladesh, Rohingya men are largely unemployed and confined to the shelters. In contrast, the Rohingya women, while continuing their domestic work, also perform other duties, such as collecting food rations, and engaging in new and largely unfamiliar roles, such as cash-for-work, casual day labour job, etc. (Ahsan, 2020). As the Rohingya society practices dominate patriarchal culture, many Rohingya women have had the experience of gender-based violence (GBV). Rohingyas have travelled from Myanmar to Bangladesh to escape persecutions, killings, and violence. However, the irony is that some cultural aspects of violence, which were prevalent in Myanmar, also travelled with them (Priddy et al., 2022). According to the data gathered by the International Rescue Committee (IRC) in their centres between July and December of 2019, one in four Rohingya women and girls in the Cox's Bazar refugee camps, had suffered gender-based violence (ICRC, 2021).

3.4.4 (e) Marriage

Marriage is very important for Rohingya people, particularly for women. It is considered a religious affair in their culture. In Myanmar, marriage is treated as the only form of security – economic and physical – for a Rohingya woman (Ripoll, 2017). In the Bangladeshi camps, however, marriage is seen as the safest way to secure a girl's livelihood as the parents are not in a position to be able to provide a livelihood for long (Ripoll, 2017). Both in Myanmar and in the Bangladeshi camps, Rohingya women are getting married at a younger age due to the lack of economic opportunities (Melnikas, et al., 2020). More than half of the Rohingya girls, who fled Myanmar ended up becoming child brides (Devi, 2019). According to Taylor

(2017) and Latiff and Harris, (2017), early marriage or child marriage remains a common cultural norm in Rohingya communities. However, early marriages of Rohingya girls results in intimate sexual violence. In addition, low reproductive health knowledge makes the Rohingya girls and women vulnerable and creates obstacles to maintaining good health (UN Women, 2018).

3.4.4 (f) Polygamy

Polygamy is infrequent amongst the Rohingyas but has a rising trend in recent years in the refugee camps (Acaps, 2022b; Leigh et al., 2020). Many researchers noted that the rising polygamy in the Bangladeshi camps were the result of the trials the refugees had faced – for example, the scarcity of men and the lack of economic opportunities in the camps (Khan, 2019). To get married in Myanmar, the Rohingyas needed to obtain permission from the authorities, which was costly and time consuming (Lewa, 2009). However, in the Bangladeshi refugee camps, while the Rohingyas no longer require any official permission to marry, no marriage is officially recorded either. The consequence of this changed circumstances is an increase of the incident of polygamy and abandonment of wives (Ripoll, 2017; Khan, 2019). Dowry is also a common practice in the Rohingya community, which sometimes works as an incentive for polygamy as already-married Rohingya men do not ask for dowry payments from subsequent wives (Acaps, 2022b). The practices of child marriage, polygamy, and dowry payments are not only the elements of Rohingya culture, but also work as adaptation strategies to the curtailed livelihood opportunities in the camps (Ripoll, 2017). However, these illegal practices result in abuse, domestic violence, sexual and gender-based violence against the Rohingya women, which ultimately affect the overall health of the Rohingya community.

3.4.4 (g) Language

The Rohingya language (Ruaingga, Rooinga or Rohingya) is an Indo-Aryan language that is primarily an oral tradition and does not have a standardised and internationally recognised written alphabet. Cultural codes and connotations of daily life are formed through language; language helps community members to cope with the challenges they face. Mitchell and Myles (2004) have stated, "language and culture are not separate, but are acquired together, with each providing support for the development of the other" (p. 235). A community can access and fully comprehend health-saving information only in their own language; they can find answers to their concerns and feel respected (Ergül, 2020). However, language works as a barrier for Rohingya people to receive proper healthcare services. They do not fully comprehend the words used at the Bangladeshi camps' healthcare facilities. For communicating with health workers or aid providers, Rohingya people rely mostly on translators fluent in the Chittagonian dialect of the Bangla language as it has some similarities with the Rohingya language (Hölzl, 2020). Still, about 33% of the Rohingyas who visited health facilities reported that they did not understand everything that's been said during consultation and did not feel that all their concerns were properly addressed (TWB, 2019). Language is considered as an important aspect of the Rohingya culture. However, many fear that the Rohingya language will be diminished or lost over time as the Rohingya children in Bangladeshi camps receive only a limited education exclusively in the Burmese and English languages (Bakali & Wasty, 2020; Hossain, 2023a).

3.4.4 (h) Music and poetry

Poetry and music (song) occupy an important place for Rohingyas and constitute a major part of the Rohingya culture. Poetry has long been associated with the Arakan (Rakhine) Muslim (Rohingya) culture dating back to the Mrauk-U (1430-1785) dynasty. In fact, for around three and a half centuries between 1430 and 1785, the Kingdom of Mrauk U held fort as a sovereign entity and enriched itself with culture and poetry (Chakraborty, 2018). The Rohingyas claim that they are the descendants of Mrauk U. Music plays an important role in the Rohingya culture. It also played an important position in resisting the onslaught of Buddhist culture when they were in Myanmar (Ripoll, 2017). Through Tarana[13] (poetry-based song), the Rohingyas try to keep their history alive. Tarana works as a way of transmitting feeling, sentiment, and emotion through songs and "is thus an excellent means of preserving identity and displaying passive resistance" (Farzana, 2011, p. 223).

Williams and Popay (1999) have observed that the potential of music to facilitate the wellbeing of an individual can be characterised through four conceptual categories: emotion and self-identification (intra-personal factor); socialisation (interpersonal factor); and agency (both intra and interpersonal factor). Poetry and music continue to occupy important roles in the lives of Rohingya refugees at the Bangladeshi camps. Mostly illiterate Rohingyas try to reclaim and express their identities through oral traditions, such as poetry recitation, performing of music, and through painting and drawing (Farzana, 2017b). Poetry and music provide comfort and boost morale during periods of stress and trauma (Andemicael, 2013). For decades, Rohingya refugees have been endured human rights violations, traumatic events, and stress. So, they have been used to using poetry and music for stress relief (Riley et al.,

[13] Tarana is the combination of sad songs, and it is used as a way for people to express lamentation. Taranas were called 'Kobita Gan (poetry song)' until about 50 years ago when the name was changed (RCMC, 2022). Rohingya refugees use Taranas to express their feelings and emotions (Farzana, 2011).

2020). Byrne (2019) observed that the writings of Rohingya refugees sometimes work as activism for their survival and raising of the Rohingya voices.

3.4.4 (i) Food

Food provides an important link to the cultural heritage of any community as it is deeply rooted in the expression of identity, values, and way of life. Specific foods are parts of family treasures as food recipes or traditional cuisines are passed on from one generation to another, thereby maintaining cultural and ancestral links. As people from different cultural backgrounds eat different kinds of food, Rohingyas have some special food habits. The 'typical' Rohingya diet is mainly made up of rice, accompanied by fish for additional curry, plus vegetables (Boutry, 2012; Khan, 2018). In Myanmar, the Rohingya people faced many challenges in organising food for themselves as their movements were restricted. Klug (2018) has asserted that the Myanmar authorities used food or hunger as a weapon to wipe out the Rohingyas. Genocidal violence against a community can wipe out its people and, at the same time, its culinary traditions. The Rohingya refugees are a good example of this assertion (Shaikh, 2021). Rohingya refugees living in the Bangladeshi camps have limited access to food as they rely on food rations provided by aid agencies. They cannot buy food from open markets as they do not have any source of income (Ahmad et al., 2020). Oh (2018) observed that humanitarian organisations are providing food to Rohingya refugees living in Bangladeshi camps solely to assuage their hunger, and not to support the social and cultural norms of the community. Food is very important for maintaining the health of a human being as it enriches the body with nutrients, vitamins, and energy. Rohingya refugees are forced to

live with an inadequate food supply in the camps, and this has a negative impact on their body and health.

3.4.4 (j) Clothes

Clothing is a basic human need. It may indicate the living standard of an individual, a family or a community (Hockin, 1960). Clothing signals the physical and mental state of an individual, which affects the ways in which the person will respond to others. Every culture has its unique clothing style, although societies often make radical moves away from their clothing traditions of the recent past (Diab, 2022). The Rohingyas traditionally follow the Indo-Burmese way of dressing (Kanu, 2022). Rohingya men wear bazu (shirt with long sleeves) and lungi or doothi (loincloths) covering their legs down to their ankles. Religious scholars (the mullahs who are essentially males) prefer wearing kurutha or kurta (a loose collarless shirt), jubba or panjabi (long clothes) together with caps; they may or may not wear turbans (Zafari, 2019). On the occasions of religious festivals or special events, Rohingya men wear kurutha, jubba or panjabi, lungi or pajamas, and a cap or "tupi" as a headgear (Sultana, 2019). This is similar to the style of clothing of local Bangladeshi Muslim men. Rohingya women typically wear a sarong (also called ta-mi, taine, or a female longyi) which is a large piece of fabric, wrapped around the waist, a blouse, and a veil or urna, which is a piece of cloth around the head. Rohingya women wear a hijab (head covering veil) or a niqab (face covering veil). Some use burqas (a black robe worn over the longyi and blouse) (Tay et al., 2018). Some Rohingya women also wear an abaya[14] dress to cover their bodies (Oxfam, 2018).

[14] Abaya, also known as an aba, is a plain, loose over-garment, a robe-like outfit, worn by some women in Islamic countries. It is a long-sleeved, floor-length dress traditionally in black colour. It is worn over street clothes when a Muslim woman leaves her home (Huda, 2019)

However, in some areas of Myanmar, the Rohingyas were restricted to wearing only traditional lungis; they could not wear a pair of pants (Doshi, 2018). As the Myanmar military personnel wear pants, local authorities outside some cities and towns restrict Rohingyas from wearing them. Any Rohingya who does so risks being arrested and fined (Doshi, 2018; Ekin, 2017). However, in the Bangladeshi refugee camps, Rohingyas can choose to wear what they fancy. Nowadays, Rohingya men wear pairs of pants and women and girls prefer three-piece dresses[15] with hijabs (Zafari, 2019). While a basic purpose of wearing clothes is to protect bodies from the elements, Rohingya refugees living in the miserable camp conditions are often unable to wear the basic clothes they need (Acaps, 2021).

3.4.5 Social Structures of Rohingyas in Myanmar and Bangladesh

3.4.5 (a) Social Structures in Myanmar

Historically, Rohingyas lived under a traditional agrarian social structure. In Myanmar, most of the Rohingyas were involved in agriculture; only a handful were involved in business or fishing (BBC Media Action, 2018). However, in every sphere of their life, they had to face government restrictions. The Rohingya society or "Samaj" was divided into various classes based on wealth, education, and religion. Wealthy educated and religious leaders, such as the mullahs (the heads of the mosque), and mulvis (the heads of the madrassas) were considered as upper class, while certain occupations including cleaners, barbers and undertakers were perceived as lower class (Ripoll, 2017; BBC Media Action, 2018). The Myanmar

[15] In today's world, woman's dress consists of three pieces — bodice, overskirt, and petticoat. Off the three-piece, boddice and overskirts are sometimes joined (Olsen, 1999, p. 97).

government imposed strict controls on the Rohingya people using various state agencies, such as the army, police, nasaka or the border guards, intelligence forces, tax authorities, property registration body etc. In the Rohingya culture, these forces and authorities were collectively known as the “Hukumat”. This “Hukumat” or the Myanmar government was the highest body of power in Myanmar for the Rohingyas.

Under the Hukumat, several villages were combined to form a village tract, administered by a Rakhine Buddhist. Under this person’s authority, each village had a village chairman who could be a “Maugh” (Rakhine Buddhist) or a Rohingya Muslim. The village chairman might be elected by the community or selected by the Hukumat (Zafari, 2019). The chairman was the local leader; his responsibilities included resolving local problems and disputes of the local community. Rohingya community or “Samaj” (literally “society”) used to select some murobbi (seniors, elders, mullas or mulvis) [Murobbi in Rohingya, literally meaning ‘guardians’ in Arabic] who helped settle any disputes within the community (Acaps, 2020a; CASS, 2020). Rohingyas generally lived in a joint family (extended families) and any disputes had to be resolved within the family by the Uji (head of the household, usually an older man) who made the final decision (Zafari, 2019). If the family failed to resolve the dispute, then they would go to the local murobbi. The murobbi, failing to resolve the matter, would forward it to the local Chairman. Thus, the family was the lowest unit of social structure for the Rohingyas in Myanmar and the Hukumat was the highest. This structure can be shown in the following diagram:

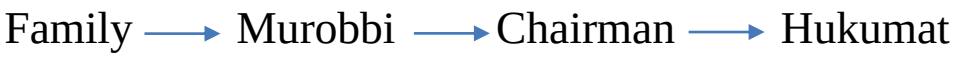
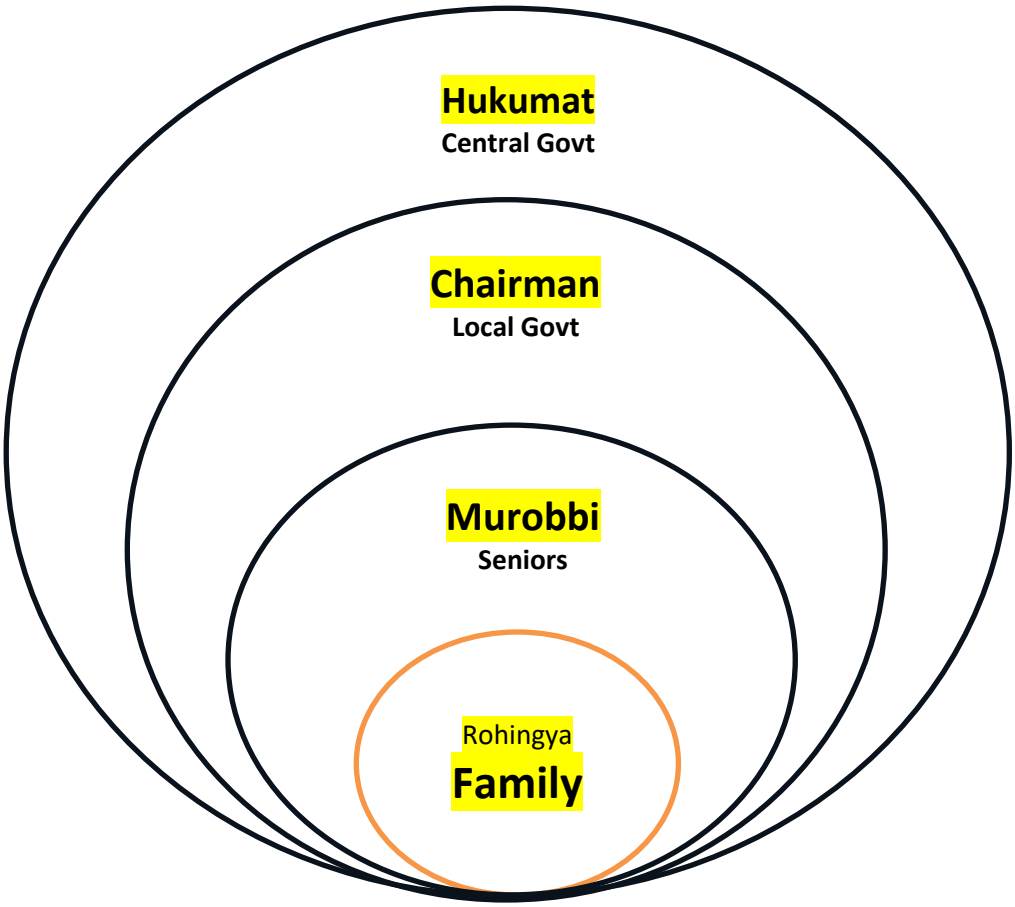


Figure 4: Social structure of the Rohingya community in Myanmar (BBC Media Action, 2018)



Source: https://reliefweb.int/report/bangladesh/power-structures-class-divisions-and-entertainment-rohingya-society-enbn and author's own research

3.4.5 (b) Social structures in Refugee camps of Bangladesh

In the Bangladeshi refugee camps, family still serves as the lowest unit of social structure in the Rohingya society. Mullahs or imams, who lead the prayer in mosques, and mulvis, who teach at the madrassas, continue to be very influential and treated as murobbi (Ripoll, 2017). In the camps, there is little or no role of the Samaj, but the murobbi (plural murobbis) still have the role of passing judgement. As the samaj has lost its power, family crises including divorce, polygamy, family dispute, and other interpersonal conflicts have become frequent in

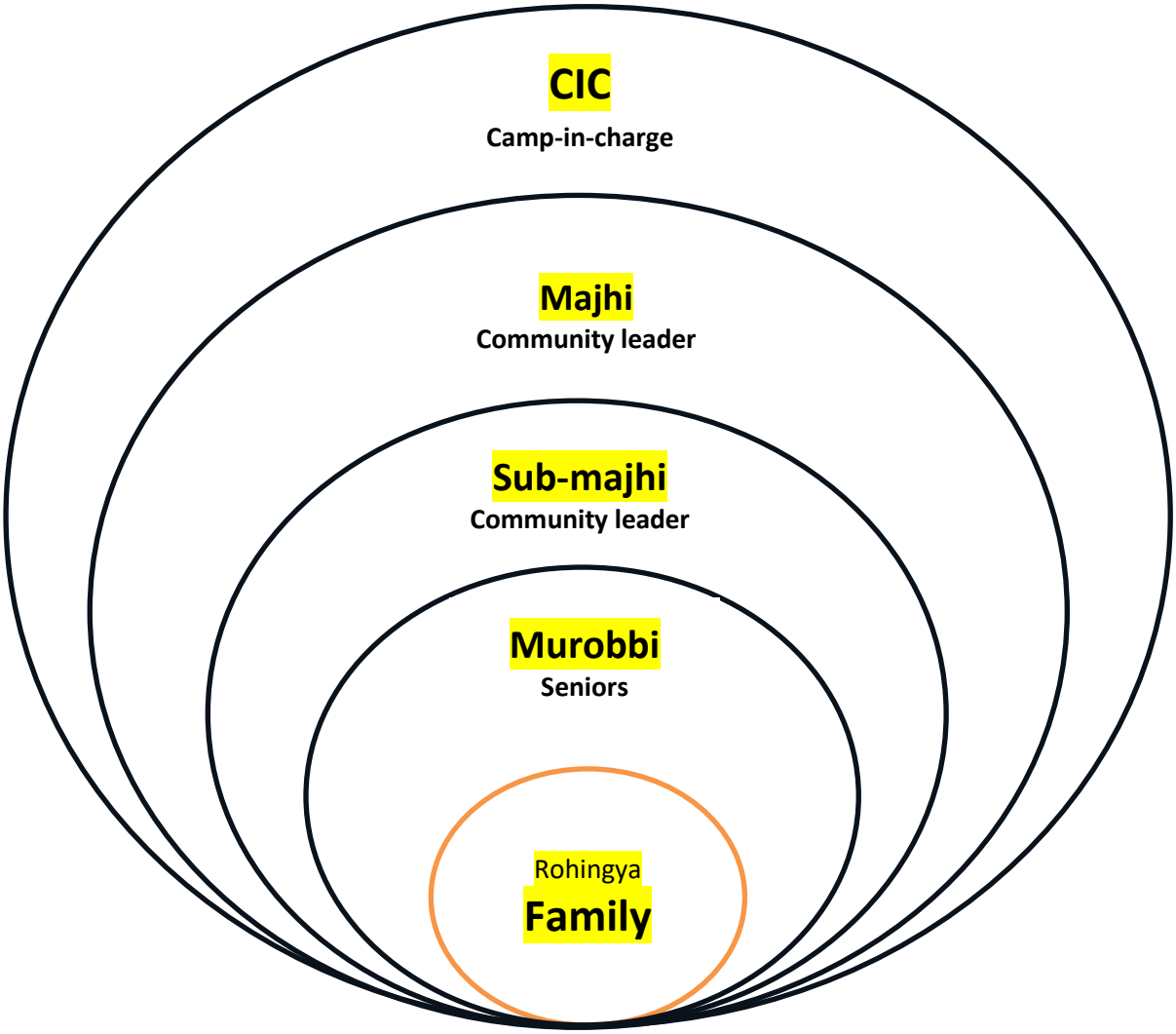
the Bangladeshi camps (Acaps, 2020a). There is no chairman position; instead, the majhi system has been introduced in the camps. A majhi looks after the Rohingyas living in one of the blocks of a camp. A camp is usually divided into various blocks and a block is divided into sub-blocks. A head majhi leads an entire camp and all majhis and sub-majhis (i.e., leaders of the blocks and sub-blocks) report to him (Pereira et al., 2021). The head majhi, in turn, reports to the camp-in-charge (CIC) to settle any disputes or meet any needs of the camp inmates (Acaps, 2018a). Thus, the current social structure in the camps can be described as follows:

Family → Murobbi → Sub-Majhi → Majhi → CIC

See Figure 5: Social structure of the Rohingya community in Bangladesh camps

The Government of Bangladesh (GoB) is the top authority in managing the affairs of all the Rohingya refugee camps. The GoB appoints the CIC (a Bangladeshi government official). The CIC work under the control and guidance of the Refugee Relief and Repatriation Commissioner (RRRC), who is a senior Bangladeshi government official. The CICs coordinate Rohingya responses in every camp (Guglielmi et al., 2021) and manage day-to-day affairs of the camp dwellers (Acaps, 2019). The office of the RRRC is located in the Cox's Bazar district town. This office assigns Bangladeshi civil servants as camp-in-charge (CIC) on a rotation basis. The RRRC is under the administrative control of the Ministry of Disaster Management and Relief (MoDMR) of the GoB. The ministry is located in Dhaka, the capital of Bangladesh.

Figure 5: Social structure of the Rohingya community in Bangladesh camps



Source: https://reliefweb.int/report/bangladesh/power-structures-class-divisions-and-entertainment-rohingya-society-enbn and author's own research

3.4.6 Agency and Voice of the Rohingyas

The Rohingyas do not have any legal identity or citizenship rights either in Myanmar or in the countries where they seek shelter. They do not have any legal rights or protection due to their stateless identity. They cannot express their voice. The Myanmar government has institutionalised discrimination towards the Rohingya people by imposing restrictions on

jobs, education, religious choice, marriage, freedom of movement and freedom of expressions (Albert & Maizland, 2020; UK Home Office, 2023). This ethnic group had some voice and representation in Myanmar before the enactment of the 1982 citizenship law that rendered them stateless. After 1982, any voice raising or protest by the Rohingyas was almost banned in Rakhine. Instead, anti-Rohingya groups staged protest rallies on a regular basis without any sanctions from the authorities (Green et al., 2015). The Myanmar security forces, on the other hand, would physically assault or shoot on the spot if there had been any form of protest or gathering by the Rohingya Muslims in Rakhine (Uddin, 2018). Majeed (2019) has alleged that, since the 1990s, those Rohingyas who tried to exercise their political rights had been imprisoned; and Rohingya political parties had been banned, denying their voice and freedom of speech.

In the Bangladesh camps, the Rohingyas have never been included as decision-making stakeholders; they can only learn later what was decided about them (Ahmed, 2018). Critics have accused the humanitarian agencies of not putting any emphasis on consulting the Rohingya refugees throughout the ongoing emergency. Only the authorities of some non-government organisations (NGOs) occasionally consult with the mahjis or Rohingya volunteers working with them (Acaps, 2021). Critics have alleged that the humanitarian agencies do not draw on the lived experiences of some Rohingya refugees who have been living in the camps for almost three decades (Ahmed, 2020). Various authorities and agencies continue to ignore or even undermine the expertise some Rohingyas that have been developed in the camps over the years by volunteering or working as translators (Ahmed, 2020). Lough et al. (2021) assert that in any humanitarian context the community should have a say in any decisions that affect their lives.

In the refugee camps of Bangladesh, the Rohingya refugees do not have any right to say anything about their living conditions, rather they are the passive end-users of the decisions made by others. They are not even allowed to protest or raise their voice against any decisions. The Bangladeshi government took some extreme punitive measures in 2019 against the Rohingyas for organising a public gathering on August 25 to mark the second anniversary of the 2017 genocide. The measures included shutting off internet access and closing down community groups and community-led schools (HRW, 2019). Hatdash (2022) observed that Bangladeshi authorities used the 2019 rally as a pretext to impose extreme measures that created an environment of fear within the camp community. The message was clear: "those who do raise their voice will receive no protection" (Hatdash, 2022). Following the incident, no rally, protest, or gathering of Rohingyas was allowed inside or outside the camps. The security forces impose strict prohibitions on any large gathering. However, in June 2022, the authorities allowed the Rohingyas living in the camps to stage a campaign, titled "let's go home," hoping to return to Myanmar. This was the first large gathering of the Rohingyas since 2019 that the Bangladeshi authorities allowed within the camps (Min, 2022). Bangladeshi authorities believe that the repatriation of Rohingyas to Myanmar is the foremost solution to this displacement crisis. In the meantime, Rohingyas' voices have not been heard even on their possible repatriation process to Myanmar (Sullivan, 2020).

3.5 Health status of Rohingyas in Myanmar

Myanmar denies citizenship rights to the Rohingyas, which leads to the denial of access to healthcare for Rohingyas in this country (Rahman et al., 2020). In Myanmar, following the military takeover in 1962, Rohingyas' civil, political and health rights began to be erased (HRW, 1996; Mahmood et al., 2017). The enactment of the 1982 citizenship law, which rendered the Rohingyas stateless, further restricted their freedom of movement and access to social services, such as education and health care (O'Brien & Hoffstaedter, 2020; Khin, 2020; Rosenthal, 2019). Ekeh and Smith (2007) mentioned that restrictions on the movement of Rohingyas became stricter from 2005, and every Rohingya required a pass even for a day trip to health clinics. In Myanmar, Rohingya individuals must apply for special permission to leave their villages for earning a living or to seek healthcare (Amnesty International, 2004; HRW, 2020b; Khin, 2019;). At present, approximately 600,000 Rohingyas, who remained in Myanmar (of whom 140,000 are internally displaced), face movement restrictions and limited access to health, education, and other social facilities (Allen, 2023; Duran et al., 2023). They are also trapped in the fighting between the Myanmar military and the ethnic Rakhine Arakan Army groups (Bauchner, 2022; Lynn, 2023).

In terms of health facilities for the Rohingyas in Myanmar, there is only one 500-bed government-run hospital (i.e., the Sittwe General Hospital) serving the entire community of the Rakhine state (Hill, 2013; HRW, 2020b; MoHS, 2017). Besides the 500-bed hospital, there are some other hospitals and private clinics in the Rakhine state where the Rohingya Muslims do not generally receive health services (Debarre, 2019). Assum (2020) has stated that, from September to December 2019, out of 26,860 patients treated at the Sittwe General Hospital, only 814 patients, or 3%, were Muslims. Yarali (2019) observed that the Rohingya Muslims in the Rakhine state had limited access to preventive health care services. There was

also a lack of preventative and diagnostic services for blood-borne diseases, such as HIV and tuberculosis. In Rakhine, there are only five health workers per 10,000 people, which falls well below the Myanmar national average of 16 per 10,000 people, and further below the WHO-recommended minimum of 23 per 10,000 people to maintain a functional healthcare system (Annan Commission, 2017). A 2014 Myanmar government report admitted that there was one physician per 158,000 Rohingya people in Rakhine, whereas the figure for non-Rohingya people was one physician per 681 persons (Mahmood et al., 2017).

Since the late 1970s, the Rohingya Muslims of Rakhine have been suffering from poor access to obstetrics care with a high prevalence of waterborne illnesses (Ives, 2016). After the 2012 communal violence, Rohingya patients were excluded from the better-equipped health care facilities. It is mentioned in a report by Physicians for Human Rights (PHR, 2016) that there are high number of security outposts scattered across Rakhine State to restrict free movement of the Rohingyas. Onerous restrictions on movement further limit Rohingyas' ability to access medical care, ultimately resulting in poor health outcomes. International humanitarian agencies have been the primary healthcare providers for the Rohingyas of Myanmar for many years (Mahmood et al., 2017; UNHCR, 2018). However, the activities of these humanitarian organisations were often limited by government-imposed restrictions, such as the requirement of travel authorisation for international staff in Rakhine. In June 2022, the UN High Commissioner for Human Rights mentioned that Myanmar’s junta government still tried to block humanitarian access in Rakhine, raising major concerns about fulfilling medical and humanitarian needs of the Rohingyas there (OHCHR, 2022).

Pocock et al. (2017) and Mahmood et al. (2017) have asserted that, due to decades of statelessness and systemic persecutions, the Rohingyas living in Rakhine have an acute

malnutrition rate, which is 50% higher than non-Rohingya residents in the state. The Rohingyas' diarrheal illness rate is five times greater than that of Myanmar's national average. In 2017, the Advisory Commission on Rakhine mentioned that there was an acute shortage of medical staff in Rakhine. Moreover, many medical staff hesitate to spend time in Muslim villages (Annan Commission, 2017). The Centre for Diversity and National Harmony in its December 2016 report stated that the immunisation coverage in Rakhine was among the lowest in the country, and there had been multiple outbreaks of vaccine-preventable diseases over the recent years (CDNH, 2016). Ripoll (2017) has stated that clinics in Rakhine are usually managed by Rakhine or Burmese staff, and communication between Rakhine and Burmese staff and Rohingya patients is problematic due to language barrier and attitude. Burmese speakers do not understand the Rohingya language and would need translation. Moreover, the Burmese treat Rohingyas with contempt, and may even refuse treatment. The Rohingyas in Rakhine have very little access to hospitals or clinics and are deprived of health care services (Islam, 2020).

Chris Lewa of the Arakan Project, an advocacy NGO, maintained that the health care facilities for the Rohingya people in Rakhine were appalling. Only a handful of the basic health needs were met; this poor health service had been prevailing even before the attacks in August 2017 (Sandford, 2018). Chris Lewa (2009) also mentioned that in the cases of serious or life-threatening situations, a few wealthy Rohingyas, who could afford the cost, would cross the Bangladeshi border and sought medical treatment there. However, most of the border crossers are unable to return due to strict restrictions on entry to Myanmar. The remaining Rohingyas in Myanmar do not have any freedom of movement and receive restricted humanitarian aid leading to incidents of preventable deaths and illnesses (HRW, 2022a).

The medical literature lacks summative health data on Rakhine's Rohingya population as free movement for the Rohingyas is still restricted (Mahmood et al., 2017; UK Home Office, 2023). Tun (2019) mentioned that most domestic and international NGOs and UN agencies were limited to offering a small number of health services in urban areas of northern Rakhine; the government's travel authorisation requirement prevents adequate access to rural areas. The media also face restrictions as they are only allowed to report from Rakhine with permission and with official escorts accompanying the media teams. The Myanmar government has restricted mobile internet services across the area (Hlaing & Fishbein, 2021). Following the military takeover on February 1, 2021, the Myanmar military junta declared a one-year state of emergency. In August 2021, army general Min Aung Hlaing declared himself the Prime Minister and extended the emergency up to August 2023 (Johnson, 2021). However, in August 2023, the nationwide emergency was extended for the next six months, and the Junta government postponed the next election date that they had pledged to hold in August 2023 (Strangio, 2023). A general nationwide curfew throughout Myanmar between 8 p.m. and 4 a.m. (Yangon 10 p.m. to 4 a.m.) has been imposed until further notice. Besides, a ban on gatherings of more than five people in public is ongoing in Myanmar (Lynn, 2021; Salem, 2023). Thus, everyone in Myanmar has been facing strict restrictions since the military takeover of state power. The suffering of the Rohingyas, who still live in Myanmar, has been exacerbated due to their stateless identity.

3.6 Health status of Rohingyas in Bangladesh

Bangladesh has a history of hosting Rohingya refugees since 1977-78 (Bhatia et al., 2018; Yunus, 1994). Alam (2019) and Kiragu et al. (2011) have observed that Bangladesh has been one of the most accepting host countries for the Rohingyas who are fleeing from persecution in Myanmar. The Rohingya people prefer Bangladesh as their next destination due to its proximity and similarity of religion and culture (Milton et al., 2017; Wali, et al., 2018). Sultana (2011) observed that the overall health and hygienic situation of the two registered refugee camps of Cox's Bazar was poor. The health situation of women and children was especially vulnerable. Prodip (2017) found that the overall health scenario at the Cox's Bazar camps might show some improvement compared to their health status in Myanmar, but children were facing widespread malnutrition. Medecins Sans Frontières (MSF) in its March 2022 report revealed that since the 2017 Rohingya exodus nothing had changed in the Bangladesh camps' health infrastructures (MSF, 2022a). In its August 2023 report MSF mentioned that "medical needs in the world's largest refugee camp remain pressing and care increasingly inadequate (MSF, 2023a)."

In August 2017, following deadly crackdown by Myanmar's army, a large number of Rohingya people crossed the Bangladeshi border in a very short time and gathered in a small area of Cox's Bazar district. It was challenging to set up services fast enough to meet their basic needs (Villasana, 2017). The humanitarian agencies and Bangladesh authorities worked against the clock to provide the Rohingya people with basic needs, including shelter, food, water, sanitation, psychosocial support, and healthcare (Brothwell, 2018). The sudden onrush of hundreds of thousands of new arrivals put a massive pressure on all health services in the Cox's Bazar area (WHO, 2017a). The health facilities in and around the areas where the Rohingyas settled reported a 150-200% increase in patient numbers, overwhelming current

capacity and resources (WHO, 2017a). Many Rohingya refugees suffered from malnutrition, communicable diseases (including vaccine-preventable and water-borne diseases), injuries, and other complaints that created immense public health challenges (WHO, 2017a).

A US foreign relations committee report (2017) and Haar et al. (2019) stated that many Rohingya refugees entered Bangladesh with injuries from gunshots, beatings, knife and other sharp instrument attacks, explosions, and fire incidents. The Rohingyas had suffered sexual and gender-based violence, blunt trauma, and other injuries related to the violence. Along with these physical injuries, the Rohingya refugees also faced war-related traumatic events, including the destruction of property, or loss of family members, which had the potential to make them suffer from psychological distress (Amnesty International, 2017). O'Connor and Seager (2012) found associations between the experience and witnessing of traumatic events and the development of depression, tension, and overall poor mental health. Tay et al. (2019) noted that Rohingya women, girls, and children were more vulnerable to mental health problems due to the gender-based violence against them perpetrated by the Myanmar authorities and Rohingya male members of their own community. Hossain et al. (2022) stated that previous injuries, the burden of disease, the emergence of COVID -19, unhygienic camp conditions, and the dark future result in anxiety, tension, and poor mental health of Rohingyas.

Chan et al. (2018) described that in emergency and crisis settings, water and sanitation, food and nutrition, shelter and non-food items, access to health services, and information were the five crucial challenges to securing the health and survival of the affected population. The Rohingya refugees have been facing all these five challenges since their arrival *en masse* in 2017. The 33 existing Rohingya refugee camps of Cox's Bazar have a population density of

over 40,000 persons per square kilometre. This means approximately 15 square metres of space per person whereas the recommended international standard for refugee camps is 45 square metres per person (Kamal et al., 2020). In the Cox's Bazar camp shanties, the kitchen area is not separated from the living space, and ventilation either does not exist or is very limited. Thus, the air quality is very poor and the Rohingyas are vulnerable to airborne or respiratory diseases (Shammi et al., 2020). Further, nearly 15 million litres of groundwater are drawn each day in the Rohingya refugee camp area of Cox's Bazar contributing to annual water shortages (Akhter et al., 2020). A high level of contamination was found in both the water source and storage facilities in the Rohingya camps, resulting in frequent water-borne diseases among camp dwellers, such as diarrhoea (Mahmud et al., 2019).

A 2022 report observed that, the Rohingya refugee camps were in critical condition as 50% of participants articulated a lack of medical resources (BHRN, 2022). Alam et al. (2019) argued that large scale health services in any humanitarian setting like Rohingya refugee camps involve challenges due to lack of resources, poor infrastructure, and limited capacity for patient follow-up. Rohingyas living in the camps have either a very irregular income or very limited access to livelihood opportunities. As a result, they are totally dependent on humanitarian aid. This situation creates obstacles to accessing improved treatment or emergency health care services if that involves any costs. Further, the Rohingya refugee camps are situated in hilly terrain, which is extremely vulnerable to natural hazards, including landslides, cyclones, waterlogging, floods, and manmade disasters, such as fires (Begum, 2023; MedGlobal, 2022) that also cause various health hazards.

3.7 Overall Health Structures available for Rohingyas in Bangladesh

Bangladesh is divided into eight major administrative regions called divisions. The eight divisions are Dhaka, Chattogram, Khulna, Mymensingh, Barishal, Rajshahi, Rangpur, and Sylhet. The formation of two more divisions, potentially named ‘Padma’ and ‘Meghna,’ breaking down the Dhaka and Chattogram divisions, have been approved in principle, though their creation has been delayed (UK Govt. Report, 2023; UNB, 2021a). Each division is further split into districts, each district into upazilas or sub-districts, and each upazila into union parishads. Bangladesh has 64 districts and 495 upazilas in its latest rearrangement (UNB, 2021b). Presently, Chattogram is the largest division of the country in terms of area and Cox’s Bazar is a district within this division. In Bangladesh's healthcare system, community clinics (CCs) and union health centres (UHCs) are the lowest level of health centres providing health services to the people (Rashid et al., 2021). Each upazila has a upazila health complex (UHC) at the upazila premises and at each of the district headquarters there is a general hospital.

The Cox’s Bazar General Hospital (“250-Bed District Sadar Hospital”) is the main public hospital to serve everyone in the district including the Rohingya refugees (Islam & Yunus, 2020). This hospital is about two and a half hours away from the Rohingya refugee camp area by road (Parmar et al., 2019). Rohingya refugee camps are located in the district’s Ukhiya and Teknaf upazilas, where two more government hospitals serve the people. They are the 30-bed Ukhiya Upazila Health Complex and 50-bed Teknaf Upazila Health Complex (30 beds are currently functional) (Humanitarian Response, 2017). These two hospitals are very close to the camp areas, between 30 to 45 minutes by road. Altogether, the above-mentioned three hospitals are the main government health facilities in the Cox’s Bazar district.

Outside the district, a large and advanced health facility is the 1313-bed Chattogram Medical College and Hospital, which is located in the port city of Chattogram and about six hours away by road from the Rohingya camp area (Elshazly et al., 2019). Rohingya refugees need a doctor's referral and permission from the camp-in-charge to visit any of these public hospitals or private clinics/hospitals in Cox's Bazar district and Chattogram city. However, the Rohingya refugees usually visit the field hospitals operated by international humanitarian agencies and health centres (primary healthcare centres, health posts, etc.) operated by local and international NGOs within or near the camps.

3.7.1 Health centres available for Rohingya refugees

Rohingya refugees receive healthcare services from the health centres located in the camp areas as they are barred from visiting public health facilities outside the camps. Most of the 33 makeshift camps in Cox's Bazar, Bangladesh, are situated in three main settlement areas, i.e., Kutupalong/Balukhali, Jamtoli and Leda/Nayapara. Only a handful are scattered in between Ukhiya and Teknaf upazilas (sub-district) of the district (JRP, 2020; UNHCR & WFP, 2019). About 80% of the Rohingya refugees in Cox's Bazar district are currently living in Ukhiya upazila (Chaki & Friedman, 2021; Rahman, 2022a). However, the concentration of refugee population in one place does not make it easier for the authorities to provide healthcare services to them. It remains a challenge for the local and relevant authorities to address the health needs of the huge number of Rohingya people. One of the issues is the sheer number of agencies involved in this task of health service. According to one commentator, more than 150 different entities including the Government of Bangladesh and United Nations agencies, and both national and international non-governmental organisations, provide health services to the Rohingya refugees (Tay et al., 2018).

The World Health Organisation (WHO), together with the Bangladeshi Ministry of Health and Family Welfare (MoHFW) and the office of the Refugee Relief and Repatriation Commissioner (RRRC), continues to provide leadership, coordination, supervision, and collaborative support to all health partners for better planning and implementation of a coordinated emergency response in Rohingya Camps (WHO, 2020a). The Civil Surgeon[16] Office (CS Office) of Cox's Bazar district, under the MoHFW, is the Bangladeshi government entity for overseeing all health sector activities in the district (Nyukuri, 2020; Uddin, 2019). The Bangladeshi health sector has adopted a three-tier coordination structure at the district, sub-district (upazila), and union levels to combat health issues (Banerjee, 2019). In the case of health management for Rohingyas, the main health sector partners at the district level form a strategic advisory group that serves the advisory role to the health sector coordinator depending on Rohingya priority needs (WHO, 2019b).

According to the Bangladeshi Ministry of Health and Family Welfare (MoHFW, 2023), the following health structures and personnel are currently (as of June 2023) operating in the 33 Rohingya camps:

- Health posts (HP): 140
- Primary Healthcare Centres (PHC): 36
- Sexual Reproductive Health (SRH) Centres: 09
- Field hospitals: 05
- Ambulance: 45
- Mental Health and Psycho-social Support (MHPSS) centre: More than 25
- No. of Doctors: 293

[16] Civil Surgeon is the chief medical officer of a district in Bangladesh. This person looks after the administration of health staff of all categories working under her/his control at the district and sub-district ("Upazila") levels. S/he is responsible for providing health education to the general population, carrying out various public health schemes, and providing health services to the public in the district (Bhattacharyya et al., 2022).

- No. of Nurses: 186
- No. of SACMO (Sub-Assistant Community Medical Officer): 224
- No. of CHW (Community Health Worker): 1259

Of the above health facilities, health posts (HP), and primary health centres (PHC) are generally situated inside the Rohingya camps. These facilities act as the first contact points of health care for Rohingya refugees (WHO situation report, 2021).

3.7.1 (a) Health Posts

A health post is comparable to the MoHFW Community Clinic (CC) but adapted to the unique context. Each health post has the capacity to provide services to 10,000 people in a year. Health posts are operational during the daytime only and built within 20 minutes walking distance from patients' homes (MoHFW & WHO, 2020).

3.7.1 (b) Primary Healthcare Centres (PHC)

A PHC is comparable to the MoHFW Union (smallest rural administrative and local government unit in Bangladesh) Health and Family Welfare Centre (UHFWC) but adapted to the unique context. Each primary health care centre has the capacity to provide services to 25,000-30,000 people in a year. PHCs have 24-hour operational facilities and built within 30 minutes walking distance from patients' homes (MoHFW & WHO, 2020). (See Figure:6 A PHC at Camp 7).

Figure 6: A Primary Healthcare Centre at Camp 7 (image taken by the author)

3.7.1 (c) Sexual Reproductive Health Centres (SRHC)

Sexual Reproductive Health Centres are situated in high needs areas within different camps to provide sexual and reproductive health services to Rohingya refugees (Mahmood et al., 2019).

3.7.1 (d) Mental Health and Psycho-social Support (MHPSS) centre

Rohingya refugees have experienced the worst forms of persecutions and violence in Myanmar. They continue to face various challenges in their daily lives in the world's largest refugee camps in Cox's Bazar. Consequently, the Rohingya communities need robust mental health and psycho-social support (MHPSS) as "there can be no health without mental health" (Prince et al., 2007, p. 859). Every UNHCR-supported primary healthcare facility has MHPSS support. The UNHCR runs another 10 dedicated MHPSS centres to provide the same services (UNHCR, 2022b). Besides BRAC[17] has 10 MHPSS centres at the Rohingya refugee camp area (UNB, 2021c).

3.7.1 (e) Ambulance service

Round the clock ambulance services are available through a medical referral for transporting critically ill Rohingya refugees to hospitals outside the camp settlements (UNHCR, 2019c). There are 45 ambulances in the 33 camps area and the ambulance fleet teams are working around the clock to meet the emergency needs (MoHFW, 2023).

3.7.1 (f) Field hospitals

A field hospital is a temporary hospital or mobile medical unit that is established to serve people in need. It takes care of casualties on-site before the diseased persons can be safely transported to more permanent facilities. The Rohingya camp site is served by five field

[17] BRAC is a leading development organisation based in Bangladesh. As an NGO Advisor, an independent Geneva-based media organisation, ranked BRAC as the world's largest non-governmental organisation (NGO) of 2020 (BRAC, 2020).

hospitals run by non-governmental organisations (NGOs) and foreign governments with a total of 340 hospital beds (5.7 beds per 10,000 population) and up to 630 hospital beds when needed (10.5 per 10,000 population) (Truelove et al., 2020). These field hospitals have the highest healthcare facilities including diagnosis and operation amenities. However, they do not have intensive care units or ICU facilities (Homaira et al., 2020). (See Figure: 7 Bangladesh Red Crescent Society Field Hospital, situated outside of Camp 7)

Figure 7: Bangladesh Red Crescent Society Field Hospital (image taken by the author)

3.7.1 (g) Health workers and refugee ratio

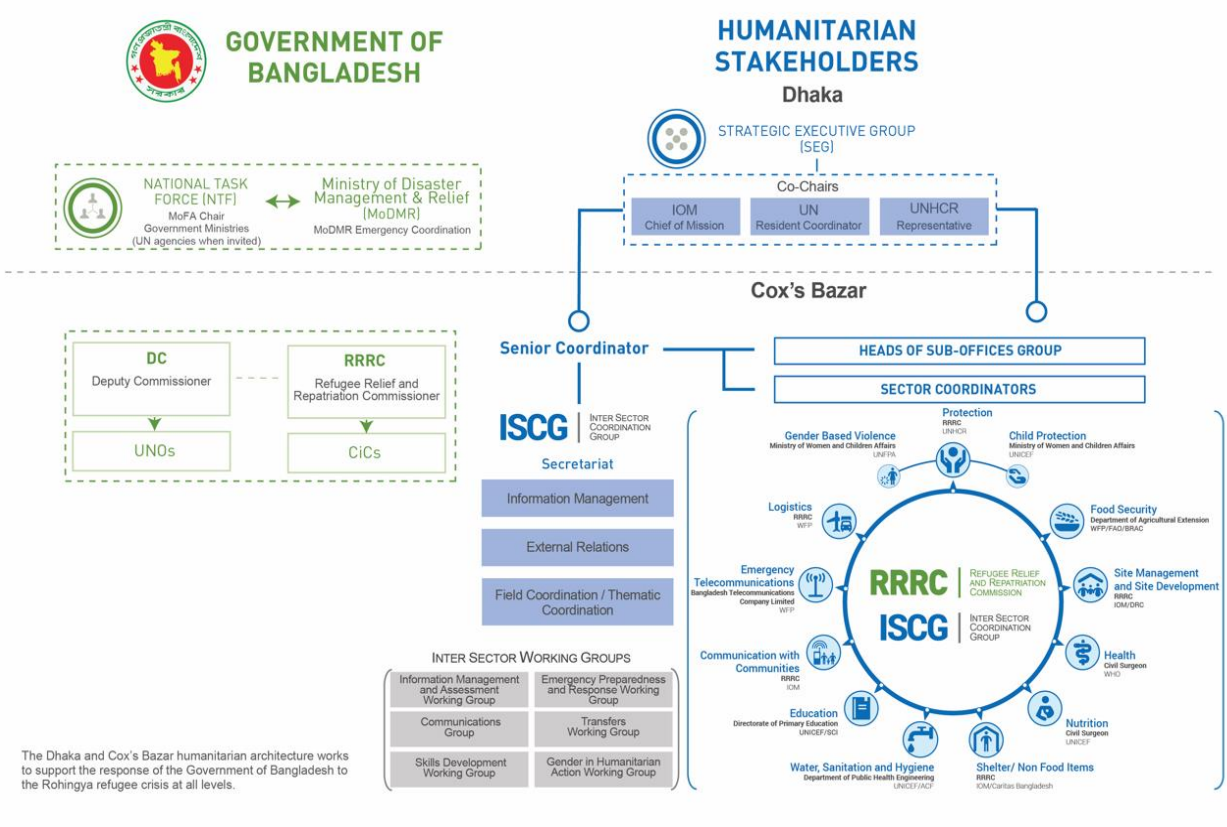
Coury (2020) and Truelove et al. (2020) cited that in Bangladesh, there were just 0.31 physicians and 0.12 nurses per 1,000 people, far below the 4.5 skilled health workers per 1,000 population recommended by the World Health Organisation. The scenario at the Rohingya camps is, understandably, more precarious. In the camps, there are approximately

3.3 physicians and 2 nurses per 10,000 refugees, which is lower than the present national average of 5.26 physicians and 4.89 nurses per 10,000 population of Bangladesh (Homaira et al., 2020; Mohiuddin, 2020; Talukder, 2022). The present doctor-patient ratio of Bangladesh (5.26 per 10,000) places the country in the second position from the bottom (before Bhutan), among the South Asian countries, according to the WHO (Shikdar, 2022). An acute shortage of trained health professionals in Bangladesh makes the scenario in the Rohingya refugee camps even more dire.

3.7.2 Overall coordination of Rohingya crisis

The Government of Bangladesh (GoB) leads and manages the Rohingya response and coordinates the efforts with its development partners to provide basic services including health care to the displaced refugees (Ainul et al., 2018; JRP, 2019). For humanitarian assistance, some coordination bodies, which vary according to the types of crises and sector, operate in (Rieger, 2021). At the national level, the GoB has a National Task Force, overseen by the Prime Minister's Office (PMO), to liaise with other government ministries and agencies (See Figure 8: Overall coordination of the Rohingya response at the national and local level). This task force, chaired by a representative of the Ministry of Foreign Affairs (MoFA), provides overall strategic guidance for the Rohingya response (Khan & Kontinen, 2022; JRP, 2021). At the field level in Cox's Bazar, the Refugee Relief and Repatriation Commissioner (RRRC) office, under the Ministry of Disaster Management and Relief, is responsible for the management and oversight of the Rohingya refugee response (Rieger, 2021). In addition, the Deputy Commissioner (DC), leading the civil administration of Cox's Bazar district, has crucial responsibilities for coordinating the Rohingya response to adjust to the needs of the local Bangladeshi host communities (JRP, 2021).

Figure 8: Overall coordination of the Rohingya response at the national and local level



Source: https://www.humanitarianresponse.info/en/operations/bangladesh/inter-sector-coordination

For international agencies, the Inter Sector Coordination Group (ISCG) (See Figure 8) is the primary means of coordination; it is managed at the national level by the Strategic Executive Group (SEG) comprising representatives of the IOM, UNHCR, UNDP, and the UN Resident Coordinator (Wake & Bryant, 2018). At the field level in Cox's Bazar, where the Senior Coordinator of the ISCG Secretariat ensures the overall coordination of the Rohingya response liaison with the RRRC, DC, and other Bangladeshi government authorities, such as Upazila Nirbahi Officer (UNO) and other officials at the upazila level (JRP, 2021). The ISCG Senior Coordinator coordinates the Heads of Sub-Offices Group (HoSOG), which brings

together the heads of all UN Agencies and members of the international and national non-governmental organisation (INGOs and NGOs) (JRP, 2021).

In short, the RRRC of the GoB and ISCG of the humanitarian agencies are the main coordinating bodies serving Rohingya refugees in Cox's Bazar, Bangladesh. (See Figure 8: Overall coordination of the Rohingya response at the national and local levels). In addition, the Bangladesh Rohingya Response NGO Platform, an independent body comprising national and international NGOs, engages in decision-making and agenda setting within coordination bodies. This guides the Rohingya humanitarian response at all levels (JRP, 2021).

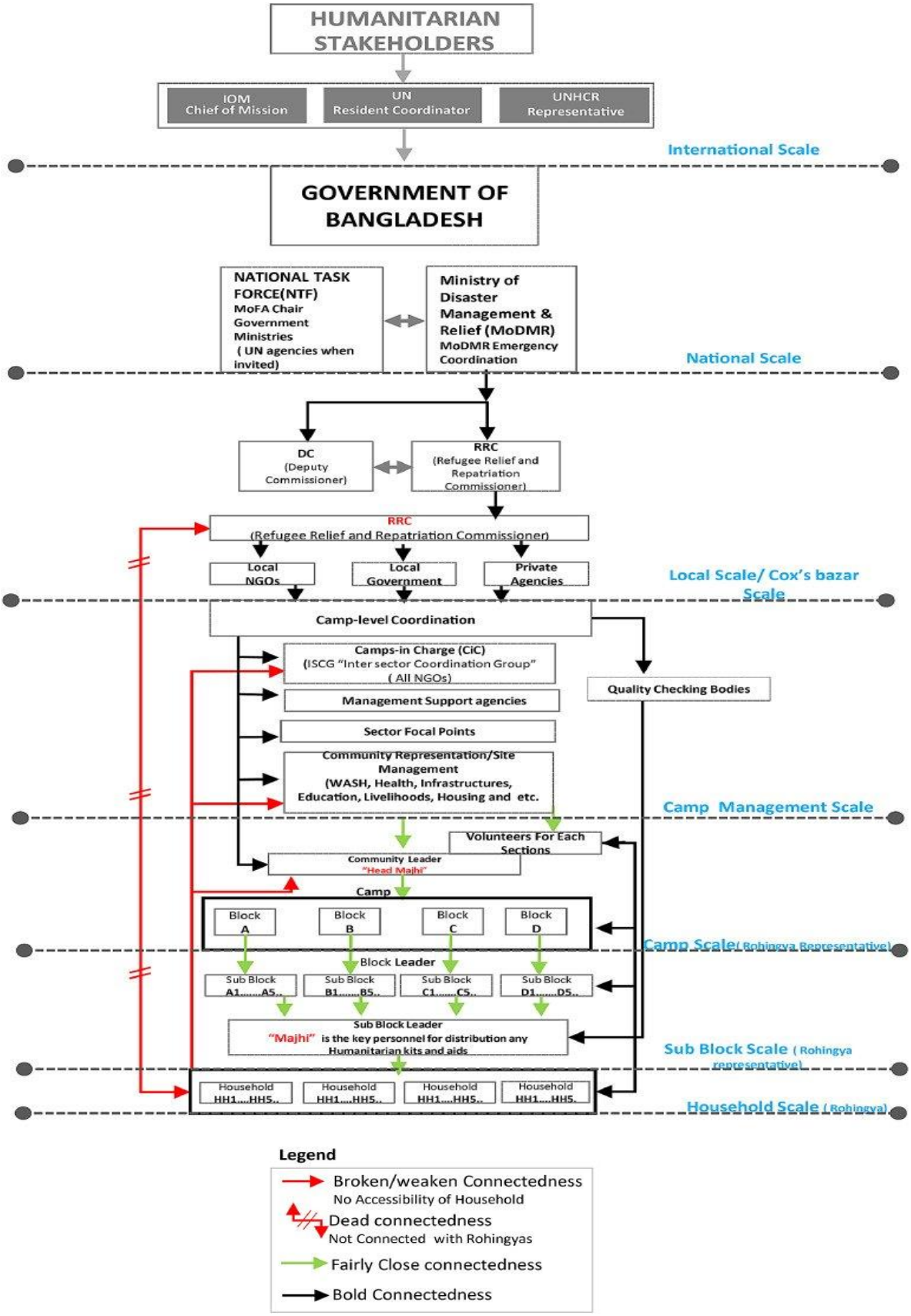
The largest of the Rohingya settlements in Cox's Bazar, Kutupalong, has 23 camps and UNHCR is responsible for the site management of 17 camps including the two registered camps (Kutupalong Registered Camp and Nayapara Registered Camp) which have existed since the 1990s (Amnesty International, 2019). The IOM is responsible for the site management of another 17 camps (now 16 camps) (Amnesty International, 2019). Since the 1977 Rohingya exodus, the UN Refugee agency UNHCR has acted as the lead international agency to work with the GoB. However, in 2013, the Bangladeshi government designated the International Organisation of Migration (IOM) as the lead agency. Then in 2017, following the massive refugee influx to Bangladesh, the situation substantially changed "with UNHCR taking on a clearer leadership role" (Hargrave et al., 2020, p.16).

In short, it may be said that the overall Rohingya response is facilitated "by a sector-based coordination mechanism, the Inter Sectoral Coordination Group (ISCG), which is accountable to a Strategic Executive Group (SEG) in Dhaka, a decision-making forum consisting of the heads of international humanitarian organisations, donors and a national

NGO representative, co-chaired by the UN Resident Coordinator, International Organisation for Migration (IOM) and UNHCR" (Hargrave et al., 2020, 16). (See Figure 9: Overall coordination of Rohingya response).

So, the decision-making part of the Rohingya coordination has been managed by various organisations in Dhaka, the capital of Bangladesh. Decisions from the capital then go to the district level, mainly to the DC (Deputy Commissioner) and to the RRRC office. The RRRC office then conveys the decision to CIC (Camp-In-Charge) of the camps and CIC is the Bangladesh government official who coordinates the overall works of an individual camp. (See Figure 9: Overall coordination of Rohingya response).

Figure 9: Overall coordination of Rohingya response

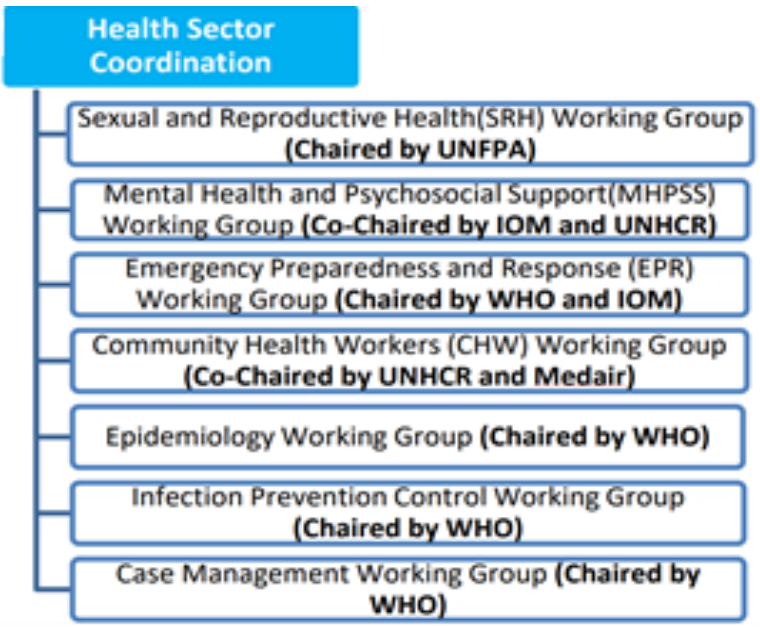


Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8352112/

3.7.2 (a) Health sector coordination

WHO, together with the Ministry of Health and Family Welfare (MoHFW) and the RRRC, continues to provide leadership, coordination, supportive supervision and collaborative support to all health partners and sectors working for the Rohingya response (Humanitarian Response, 2021). At the district level in Cox's Bazar, a Strategic Advisory Group (SAG) was formed to manage Rohingya health matters, including even Covid-19 issues. This SAG was comprised of representatives from the MoHFW coordination centre, the RRRC health unit, Health Sector Working Group coordinators, the UN, INGOs, and NGOs. SAG works as an advisory body to the Health Sector coordinator (Humanitarian Response, 2021). Currently, there are seven technical working groups in the sector coordinating different health activities at the district level which ensure the minimum standards of healthcare for Rohingya refugees (See Figure 10: Health sector coordination of Rohingya response at district level).

Figure 10: Health sector coordination of Rohingya response at district level



Source: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/health_sector_bulletin_16.pdf

3.7.3 Camp administration and management

The Government of Bangladesh is solely responsible for the administration and management of the Rohingya refugee camps at Cox's Bazar. The government appoints Camp Administrators, Camp-in-Charge (CICs), and Assistant Camp-in-Charge (ACICs) to run and manage the camps. The CICs have their offices in each camp with appropriate logistic supports provided by the government (UNHCR, 2020b). Any work relating to refugee affairs or refugee camps must be approved or coordinated by the CIC (UN Women, 2018).

3.7.3 (a) Rohingya refugee camps

A refugee camp is a place where people who flee their country to escape persecution, violence, war, or conflict, can live safely. Refugee camps are usually built close to borders of the country in which the displaced people originate and are established by host countries or an international organisation, such as UNHCR or ICRC. Refugee camps are generally designed as a short-term solution to keep people safe during specific emergencies. However, emergency situations can become extended, resulting in people living in camps for years or even decades (UNHCR, 2021). In Bangladesh, the Rohingya refugee camps were established by the GoB with the help of international donor agencies. Bangladesh has a long history of establishing refugee camps for the Rohingyas. This country gained independence in 1971; it started to provide shelters to the displaced Rohingya people after just six years of its independence.

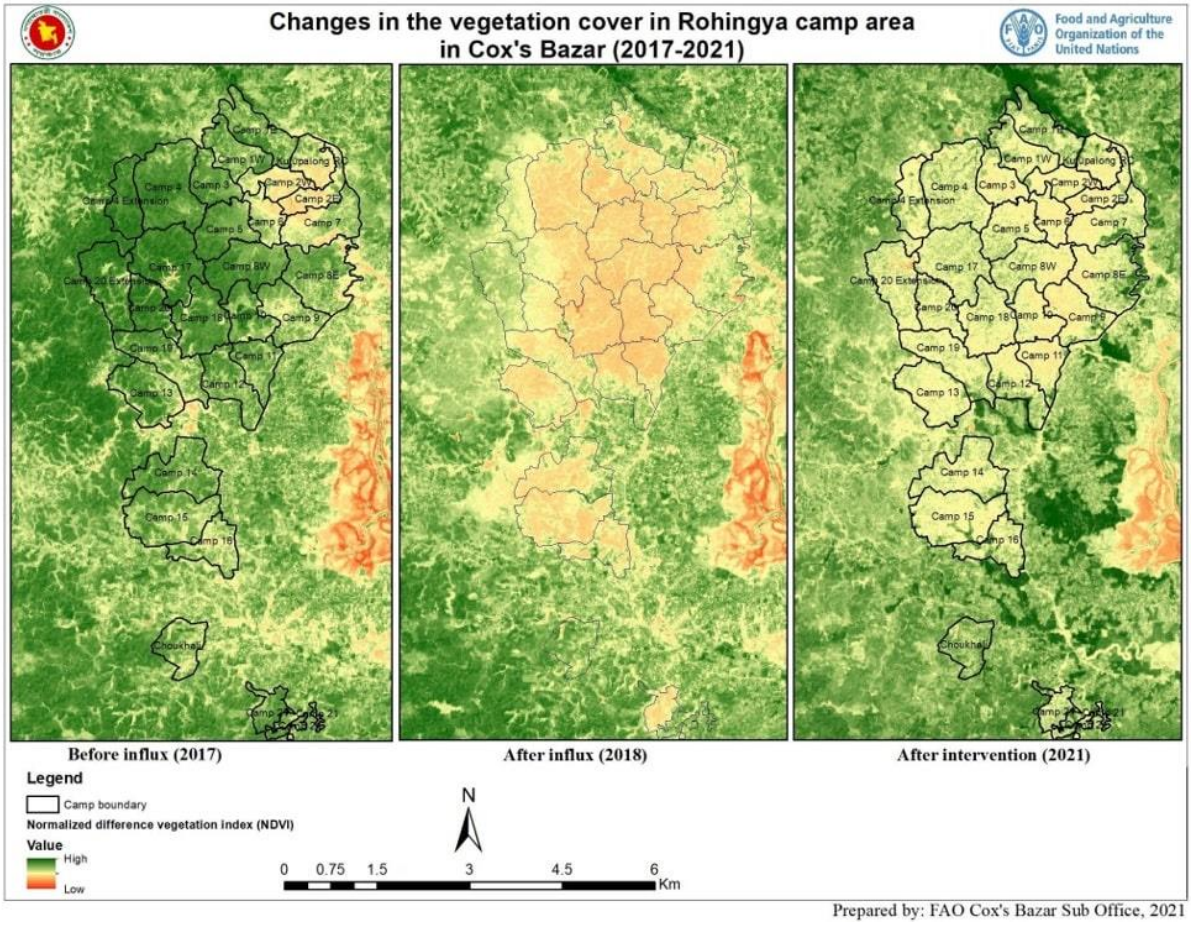
In 1977-78, when more than 250,000 Rohingyas landed in Bangladesh, 12 refugee camps were established in the Cox's Bazar area and another in the Bandarban area, which was under

the then Chittagong Hill Tracts district (HRW, 2000). Following this exodus, Bangladesh and Burma (Myanmar's official name at that time) reached an agreement to return most of the Rohingya refugees to their homeland. Later, all camps of were closed (Akhter & Kusakabe, 2014). Again in 1991-92, more than 270,000 Rohingyas fled to Bangladesh, and as many as 20 camps were established in the Cox's Bazar area to shelter them (Yesmin, 2016). This time, too, another agreement between Bangladesh and Myanmar enabled the repatriation of most of the Rohingyas. However, several thousand of Rohingyas stayed back, and some returnees re-entered from Myanmar (Rahman, 2022b). During this period, all refugee camps in Bangladesh were closed except two. The remaining two camps, located at Nayapara and Kutupalong, are still operating as registered camps today (MSF, 2020b). Including the previous two, 32 more new Rohingya refugee camps were established in the Cox's Bazar area after the latest and highest exodus of more than 750,000 Rohingyas towards Bangladesh since August 2017. However, among the new 32 camps, one camp was closed by the GoB in 2021 and now there are 33 camps in the Cox's Bazar district.

Cox's Bazar district, with an area of 2,491.86 square kilometres, is the host region where almost all the Rohingya refugees have been given shelter by Bangladesh (Khuda, 2020). Initially, the GoB allocated 2,000 acres of land in 2017 to establish camps and host the Rohingya refugees in Ukhia, Teknaf and Ramu upazilas (sub-districts) of Cox's Bazar. Later, the government added another 1,000 acres of forest land to build the refugee camps (IOM, 2017; JRP, 2020; Rogers, 2017). Currently, a total of 6,614 acres of land have been used to build the 33 makeshift camps in Cox's Bazar. However, the Bangladeshi government had to clear up a total of 8,001 acres of forest land (camps on 6,164 acres and the remaining 1,837 acres adjoining) to build these settlements (Khan, 2022). Of the 6,164 acres of land used to build the Rohingya settlements, 4,136.52 acres were natural forest and 2027.50 acres planted

forest (Hasan, 2019). The refugee camps were built destroying a huge area of forests; moreover, Rohingya refugees extensively used trees and tree parts as cooking fuel resulting in significant changes to the camp area's vegetation scenario, evident in the GoB map. [See Figure 11: Change in vegetation in Cox's Bazar by the camps (2017-2021)].

Figure 11: Change in vegetation in Cox's Bazar by the camps (2017-2021)



Source: https://www.undrr.org/news/involving-rohingya-refugees-reforestation-bangladesh-reduce-disaster-risks

Following the latest 2017 exodus, all 34 camps (now 33) were built in Teknaf and Ukhia upazilas of Cox's Bazar (JRP, 2020). Of them, 26 camps are located in Ukhiya and eight (now seven) in Teknaf (Hasan, 2019). Out of the 26 camps in Ukhiya, 23 are in the Kutupalong refugee camp mega network (the largest refugee camp in the world),

accommodating a total of 631,083 Rohingya people (Amnesty International, 2019; UNHCR Mapping Unit, 2018). The rest of the Rohingyas are living in other settlement camps of Ukhiya and Teknaf.

3.7.3 (b) Rohingya refugee population

The majority of Rohingya refugees are now living in 33 camps of Cox's Bazar, Bangladesh. Besides, some Rohingyas live in Cox's Bazar Sadar and Ramu upazilas of the district, but they live alongside the host community instead of in any designated camps. Because of cultural and religious similarities, many early Rohingya refugees have mingled with the host communities of Cox's Bazar (Islam et al., 2023). As of 30 June 2023, the total number of Rohingya population (documented by UNHCR and GoB) staying in Bangladesh is 961,729, with the majority staying in the camps. Only some 30,282 have been shifted to Bhasan Char[18]. (See Table 1: Breakdown of Rohingyas in each camp, by age and gender).

So, as of 30 June 2023 the existing number of Rohingyas (official figure) in Bangladesh is 961,729. The breakdown is shown below:

A. Total no. of Rohingyas at 33 camps of Cox's Bazar : 931,447

B. Total no. of Rohingyas at Bhasan Char : 30,282

Total : **961,729**

Source: UNHCR Data (https://data2.unhcr.org/en/documents/download/101850)

[18] Bhasan Char is an island located in Bangladesh's Bay of Bengal. It is located around 60 kilometres from the mainland. The island is also known as Char Piya and was known as Thengar Char until 2019. Bangladesh government has built a rehabilitation project in Bhasan Char, for around 100,000 Rohingyas to be shifted from Cox's Bazar (Islam & Siddika, 2022).

Table 1: Breakdown of Rohingyas in each camp, by age and gender

UNHCR The UN Refugee Agency

ROHINGYA REFUGEE RESPONSE/BANGLADESH

Annex I-A

Age and gender breakdown by camp

Camp	Total Families	Total Individuals	below 1 year Infant		between 1-4 year Children		between 5-11 year Children		between 12-17 year Children		between 18-59 year Adult		60+ Elderly	
			Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Camp 1E	8,749	41,533	309	308	2,866	2,890	4,242	4,488	2,902	3,033	10,002	8,657	795	1,041
Camp 1W	8,286	39,661	280	270	2,635	2,782	4,160	4,259	2,730	2,909	9,680	8,107	815	1,034
Camp 2E	5,952	27,181	169	182	1,977	2,029	3,021	3,033	1,949	2,210	6,671	4,989	427	524
Camp 2W	5,338	24,921	173	177	1,764	1,899	2,557	2,771	1,836	1,899	6,114	4,760	409	562
Camp 3	7,974	37,642	306	312	2,799	2,794	4,039	4,157	2,466	2,689	8,981	7,507	716	876
Camp 4	7,439	34,172	270	315	2,723	2,898	3,510	3,751	2,134	2,291	8,345	6,706	544	685
Camp 4 Ext	1,993	8,989	64	79	692	716	972	1,085	558	587	2,190	1,708	133	205
Camp 5	5,734	27,244	235	252	2,060	2,206	3,036	3,165	1,708	1,868	6,469	5,243	442	560
Camp 6	5,081	25,771	193	200	2,030	2,041	2,942	2,987	1,663	1,820	5,911	4,973	415	596
Camp 7	8,274	39,992	277	293	2,801	3,049	4,525	4,680	2,613	2,841	9,585	7,842	639	847
Camp 8E	6,435	31,926	226	198	2,091	2,273	3,372	3,506	2,120	2,267	7,881	6,612	569	811
Camp 8W	6,736	33,200	196	230	2,305	2,470	3,755	3,750	2,253	2,407	7,921	6,636	528	749
Camp 9	7,284	35,413	254	278	2,418	2,528	3,754	3,825	2,439	2,551	8,635	7,261	631	839
Camp 10	6,391	31,471	209	210	2,262	2,295	3,384	3,523	2,033	2,280	7,758	6,278	543	696
Camp 11	6,357	32,241	218	200	2,179	2,203	3,509	3,557	2,259	2,359	7,704	6,740	554	759
Camp 12	5,689	28,462	175	154	1,794	1,907	3,054	3,275	1,993	2,190	7,028	5,755	509	628
Camp 13	9,074	44,921	339	334	3,002	3,234	4,771	5,071	3,109	3,331	10,879	9,053	761	1,037
Camp 14	6,879	35,088	239	238	2,450	2,374	3,871	4,070	2,390	2,713	8,343	6,917	642	841
Camp 15	11,511	56,591	343	363	3,894	4,060	6,019	6,213	3,786	4,125	13,607	11,630	1,137	1,414
Camp 16	4,613	22,116	86	100	1,442	1,521	2,426	2,518	1,567	1,731	5,350	4,503	346	526
Camp 17	4,066	18,990	166	154	1,462	1,606	2,038	2,143	1,227	1,296	4,590	3,645	273	390
Camp 18	6,322	30,040	212	182	2,289	2,514	3,340	3,454	1,855	2,017	7,309	5,792	440	636
Camp 19	5,326	26,575	234	257	1,790	1,887	2,786	2,900	1,779	2,028	6,550	5,324	469	571
Camp 20	1,793	8,385	72	60	710	687	881	941	537	574	2,040	1,620	110	153
Camp 20 Ext	2,461	11,457	104	124	922	951	1,226	1,347	704	742	2,794	2,166	166	211
Camp 21	3,651	16,548	96	108	1,201	1,207	1,798	1,821	1,127	1,172	4,033	3,386	269	330
Camp 22	4,494	23,352	180	190	1,568	1,672	2,462	2,620	1,735	1,763	5,479	4,744	375	564
Camp 24	5,617	26,541	111	115	1,678	1,786	2,807	2,901	2,163	2,230	6,754	5,079	412	505
Camp 25	1,834	9,148	48	51	538	550	1,004	1,048	728	733	2,294	1,781	175	198
Camp 26	8,976	42,718	200	203	2,860	3,012	4,689	4,776	3,172	3,438	10,778	8,017	712	861
Camp 27	3,492	17,072	69	74	1,049	1,160	1,863	1,893	1,314	1,373	4,246	3,384	294	353
Bhasan Char	7,478	30,282	519	558	2,551	2,616	3,383	3,452	1,930	1,916	6,899	5,813	263	382
Kutupalong RC*	3,681	18,289	184	176	954	959	1,472	1,684	1,491	1,506	5,015	4,267	276	305
Nayapara RC*	4,255	23,295	85	80	1,181	1,169	1,918	1,982	1,903	1,877	6,877	5,384	427	412
Other**	156	502	-	-	8	7	78	74	54	54	146	58	14	9
Total	199,391	961,729	6,841	7,025	66,945	69,952	102,664	106,720	66,227	70,820	234,858	192,337	16,230	21,110

*Population in Kutupalong RC and Nayapara RC includes newly registered refugees/FDMN and registered refugees from 1990s.
**Refugees pending validation of exact camp location.

Creation date: 30 Jun 2023 Sources: GoB-UNHCR Joint Registration Exercise

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Joint GoB- UNHCR POPULATION FACTSHEET BANGLADESH

Source: https://data2.unhcr.org/en/documents/details/101851

3.7.3 (c) Camp infrastructures

Each camp of Cox's Bazar is divided into blocks to make them more manageable for the Bangladeshi authorities and service providers (Amnesty International, 2019; JRP, 2020). The number of blocks in a camp is not fixed; it can be as few as two or as many as 120 (Acaps, 2018a; Amnesty International, 2019). Each block has an average of 500 Rohingya residents (or roughly 100 households or makeshift shelters) (Acaps, 2018a; Amnesty International, 2019). Each block is again divided into sub-blocks, which serve as the smallest administrative subunit of each camp (Filipski et al., 2021).

The makeshift shelters of the Rohingyas are made of mud, wood, bamboo, plastic, or tarpaulin. The Bangladeshi government has imposed a ban on permanent structures inside the camps (Hossain, 2020). The average size of Rohingya households is 4.6 persons in the camps in small makeshift shelters (of 11 square metres, one room) (Khan et al., 2020). In most of the cases, all the members of a Rohingya refugee family share their shelters that often comprise of one single room (Kamal et al., 2020; Truelove et al., 2020). The makeshift shelters have poor drainage and sewerage systems and lack proper waste management facilities (Shapna et al., 2023). Almost all water and hygiene facilities in the camps are public and overcrowded (Truelove et al. 2020). Around 20 or more Rohingya people share a single outdoor latrine with long waiting times for washing and bathing (Kamal et al., 2020; Khuda, 2020). A combination of high population density and limited health services put the Rohingya refugees at high risk for infection and disease.

3.7.4 Camp hierarchy

The Rohingya camps are governed by a hierarchical intersection of the parties of GoB (RRRC, CIC, Security forces), humanitarian actors (UN, NGOs, INGOs), and local community leaders (majhis, volunteers, community elders). These various actors have direct and indirect impact on the lives of Rohingya refugees, as they form a "patchwork of powerholders and all engaged in policing or dispute resolution activities in various ways (McConnachie, 2014, p. 59)." However, as mentioned earlier, GoB is the main authority here in managing the Rohingya refugee camps, and government (RRRC) appointed camp-in-charge (CIC) is the main actor of any camp.

3.7.4 (a) RRRC

The office of the Refugee Relief and Repatriation Commissioner (RRRC) was established to administer the Rohingya refugees who fled into Bangladesh in the early 1990s. Following the latest 2017 Rohingya exodus, the RRRC oversees the entire Rohingya population living in Bangladesh. This office works under the Ministry of Disaster Management and Relief and is located in Cox's Bazar town. The RRRC is responsible for the management and appointment of CIC, works as an interlocutor with the humanitarian agencies, and looks after overall management of the Rohingya response at Cox's Bazar (Krehm & Shahan, 2019).

3.7.4 (b) CIC

As stated earlier, the Bangladeshi government appoints an official as camp-in-charge (CIC) for every camp. This official makes decisions regarding camp management, planning, and dispute resolution (Khan & Minca, 2022). The CIC, appointed through the RRRC, is responsible for the administration and coordination of services of an individual camp. The CIC also liaises with other governments and humanitarian actors. In short, this official is the front-line decision maker and influences every actor present in the camps. In some camps, an Assistant CIC assists the CIC and works as CIC when needed. As a convention, a male government official is appointed as a CIC or Assistant CIC. In more than 30 years, the RRRC office has appointed only one woman as an Assistant CIC of a Rohingya refugee camp (UN Women, 2019a, 2019b).

3.7.4 (c) Security forces

The Bangladeshi government appoints its various security forces, such as the Bangladesh Army, Border Guard Bangladesh (BGB), Police, Rapid Action Battalion (RAB) of police and the paramilitary Bangladesh Ansar forces at the camp area to maintain safety and security in the Rohingya refugee camps. The Army, BGB and RAB members remain on duty on a regular basis to ensure the overall security of the camps. Until June 2020, the Cox's Bazar district police were responsible for maintaining security inside the camps. However, since July 2020, they have been replaced by the Armed Police Battalion (APBn) forces to ensure law and order inside the refugee camps (Jinnat & Khan 2020). The APBn forces have been deployed at each gate of the Rohingya camps to ensure security and to check everybody's entry or exit (Rahman, 2022a).

3.7.4 (d) Majhi

The ‘majhi system’ was introduced in the refugee camps after the 1991 Rohingya influx. The majhi system had been abolished in 2007 in the two registered camps (Nayapara and Kutupalong) but it was revived after the 2017 Rohingya arrivals (Acaps, 2018a). ‘Majhi’ is a Bengali word, which means ‘boat skipper’ or ‘boat captain.’ However, in the refugee camps, a ‘majhi’ is a Rohingya community leader who looks after the people of one block or sub-block of a camp. As stated earlier, every Rohingya camp is divided into several blocks and each block is led by a majhi (TWB, 2020). A block is again divided into sub-blocks. The authorities select a ‘sub-majhi’ for a sub-block. A majhi serves as a focal point for CICs and camp management. Most of the majhis were appointed in late 2017 or early 2018 on an ad hoc basis (Amnesty International, 2019).

Under this system, a Head Majhi works for an entire camp; all majhis and sub-majhis report their activities to the Head Majhi (Pereira et al., 2021). The Head Majhi, in turn, reports to CIC whenever needed; for example, settling any disputes among the camp dwellers (Acaps, 2018a). However, the majhi system is chaotic and has its critics in the Rohingya camps. Some have the view that majhis do not properly represent the Rohingyas as they were appointed by the Bangladeshi authorities rather than elected by the Rohingya community. The majhis hold considerable power – both formally and informally that result in corrupt behaviour by some (Sullivan, 2020). A few majhis even face allegations of sexual abuse and exploitation (Krehm & Shahan, 2019).

3.7.4 (e) Volunteers

The volunteers are the individuals who support the humanitarian assistance provided in the Rohingya refugee camps. Most of the volunteers are Rohingyas; men and women who have been forced to flee their home to escape conflict and persecution and now live in the camps. These volunteers give their time and effort to help improve the communities they live in, in any way they can through their voluntary activities (Relief International, 2022). Volunteers are sometimes nominated by majhis and/or CIC, but some organisations also engage them in an informal recruitment process (Krehm & Shahan, 2019).

3.7.4 (f) Camp Block Committees

The Bangladeshi authorities established camp and block committees at the Kutupalong and Nayapara registered camps in 2007 following the abolishment of the majhi system (Krehm & Shahan, 2019). As stated earlier, the majhi system was reintroduced in 2017 in the Rohingya refugee camps. However, the authorities are yet to introduce camp and block committees in all camps because the guidelines for these committees are still awaiting endorsement by the Bangladesh government. The aim of these committees is to provide an accountable and representative governance mechanism instead of the majhi system. Currently, only four camps have this camp and block committee in operation. The UNHCR is interested in implementing it in all remaining camps (Acaps, 2022c; Grunebaum, 2019a).

3.8 Major Health Problems of Rohingya Refugees

With so many people living in crowded conditions and with limited facilities, health risks are extremely high in the Rohingya refugee Camps of Cox's Bazar, Bangladesh. Although all treatment, medications, and diagnostic tests are free of charge for the refugees living at the camps, they are still vulnerable in the challenging circumstances and struggle to meet their healthcare needs. Six years after the 2017 exodus, Rohingya refugees still face multiple health challenges in Bangladesh including malnutrition, unexplained fever, diarrhoea, diabetes, and HIV/AIDS.

3.8.1 Malnutrition

Malnutrition is the major health problem for the world's refugee communities including the Rohingya refugees in Bangladesh. In November 2017, a few international organisations observed that one in four Rohingya children, who entered in Bangladesh, were malnourished. These organisations stated that tens of thousands of children were facing a very real risk of death due to malnutrition (Hodal, 2017; Save the Children, 2017). UNICEF said that the malnutrition rate among the Rohingya children of northern Rakhine was already above the emergency threshold; the condition further deteriorated due to the long perilous journey the Rohingyas undertook across the border and poor living conditions in the Bangladeshi camps (UNICEF, 2017a).

Between late 2017 and December 2020, the prevalence of global acute malnutrition (GAM) in the Rohingya community fell to 11% from 19%, but more than 30% still suffer from chronic malnutrition and 55% of children aged between 6 and 23 months were found to be

anaemic (Jean, 2020; UNHCR & WFP, 2021). Because of severe malnutrition, one-third (34.1%) of all Rohingya children under five years were found to be stunted in 2020 (UNHCR & WFP, 2021). Malnutrition is still highly prevalent among Rohingya refugees in the Cox's Bazar camps, especially among Rohingya children (Al Fidah et al., 2023; Global Report on Food Crisis, 2022). Access to food is also a challenge for the Rohingyas. In the Rohingya refugee camps, low food security, alongside unhygienic and crowded living conditions have resulted in extreme levels of malnutrition (Jubayer et al., 2023; Panorat, 2022).

3.8.2 Vaccination

The Rohingya people lack the protection of routine immunisations, which makes them particularly vulnerable to infectious diseases. Their access to healthcare was severely restricted in Myanmar with decades-long persecution. They did not receive the basic childhood vaccines recommended and championed by the WHO since the 1970s through its Expanded Programme on Immunisation (EPI) effort (Beaubien, 2019). The EPI includes vaccinations for children from 6 weeks to 15 months against diphtheria, pertussis, tetanus, hepatitis-B, Hib, polio, pneumonia, tuberculosis, measles and rubella (UNICEF, 2022c). Bhatia et al. (2018) found that 42.9% of Rohingya children under the age of four had not received even a single dose of an injectable vaccine in Myanmar, and only 2.8% had received five or more doses.

The Rohingya refugees did not have any previous history of vaccination when they arrived in Bangladesh following the 2017 genocide (Mair et al., 2020; WHO, 2020b). Without vaccines, entire Rohingya communities were at risk of serious illnesses and disability from vaccine-preventable diseases (VPD) like measles, diphtheria, pneumonia, tuberculosis, Hepatitis B

and polio (Feldstein et al., 2020; Mair et al., 2020; WHO, 2020b). Following an increase in the number of suspected cases of diphtheria and measles among the newly arrived Rohingyas in Cox's Bazar, the Government of Bangladesh (GoB) and its UN partners stepped up immunisation efforts among these new arrivals (UNICEF, 2017b). To contain the spread of these diseases, the most important measure in 2017 was to ensure vaccination coverage in the shortest possible time. Immediate then the Bangladeshi Ministry of Health and Family Welfare (MoHFW) started a mass vaccination campaign at the Rohingya refugee camps in Cox's Bazar with the help of its partners (MSF, 2017).

Within two weeks of the mass Rohingya arrival in August 2017, the Government of Bangladesh organised the first measles-rubella vaccination campaign for Rohingya children with support from WHO, UNICEF and other partners (WHO, 2020b). The public health response at the early stage of the Rohingya arrival included several rounds of major vaccination campaigns against cholera, measles, and diphtheria (WHO, 2018a). In 2020, 55 health facilities at the Rohingya camps were also used as fixed immunisation sites and another 60 health facilities as outreach sites for vaccination of Rohingyas (WHO, 2020b). In 2021, during the COVID -19 vaccination campaign, 59 health facilities were used as fixed immunisation sites and 66 vaccination teams conducted outreach sessions both in community and healthcare facilities to guarantee the continuation of routine immunisation programs in the Rohingya camps (WHO, 2021a).

Vaccines are crucial public health measures to fight vaccine-preventable diseases, e.g., diphtheria, measles, cholera etc. After the 2017 exodus, there were mass vaccination campaigns for diphtheria, measles, cholera etc. at the camps. Every year, routine immunisation campaigns including EPI are conducted in the Rohingya refugee camps to

prevent communicable diseases (WHO, 2020b). Despite the efforts of the Bangladeshi government and its UN partners to vaccinate Rohingyas, however, poor health-seeking behaviour and fear of injections continue to prevent some Rohingyas from attending routine immunisation sessions (WHO, 2020a). Routine immunisation campaigns among the Rohingyas were disrupted during the COVID -19 pandemic in 2020 and 2021. However, from 2021, the routine immunisation programs resumed in the Rohingya refugee camp area, and they have been continuing along with the COVID -19 vaccination (Al Amin, 2022).

3.8.3 Communicable Diseases

Communicable diseases, also known as infectious diseases or transmissible diseases, can be transmitted either directly or indirectly from one source to another by an infectious agent like a virus, or bacteria, or fungi. As Rohingya refugees are living in congested camps, they are at high risk of getting infected by communicable diseases like COVID-19, diarrhoea, diphtheria, measles, skin disease, HIV/AIDs etc.

3.8.3 (a) COVID-19

COVID-19 (Coronavirus Disease-19) is a contagious disease caused by a virus that originated in Wuhan, China, in late 2019. The first case of a COVID-19 patient in Bangladesh was reported on March 8, 2020. In the Rohingya camps, the first COVID case was reported on May 14, 2020. Rohingya refugee camps have high population densities, making them more vulnerable to the COVID-19 pandemic. Islam et al. (2020) have mentioned that the population density per square kilometre in the Rohingya camps is 40 times higher than the

average population density in Bangladesh. Khan et al. (2020) have stated that each Rohingya family in the Cox's Bazar camps, with an average of 4.6 members, lives in a bamboo and tarpaulin makeshift shelter of 11 square metres, in which social distancing is entirely impossible. COVID-19 testing was scarce in the camps. Moreover, many Rohingya refugees with COVID-9 symptoms were not interested in seeking help with treatment or getting tested in the camps (Banik et al., 2020).

There were fears that the outbreak of COVID-19 in the Cox's Bazar refugee camps could be devastating but the Rohingya refugee population was actively participating in response efforts to prevent and manage the threat of COVID-19 (Brown, 2020). Although maintaining adequate distance from each other was impossible in the congested camps, Rohingya refugees reportedly stayed at home as much as possible to prevent the spread of the viral disease. As of August 2023, a total of 6,818 COVID-19 cases had been reported among the Rohingya population with only 46 deaths due to the disease (WHO situation report, 2023).

Bangladesh started its COVID-19 vaccination campaign in February 2021. Within one year, 69% of the country's population had been fully vaccinated (i.e., two doses) (UNICEF, 2022d). The COVID-19 vaccination for the Rohingyas in Cox's Bazar camps started in August 2021. By February 2022, 88% of the Rohingya population (379,320) above 18 years of age had received at least one dose of COVID -19 vaccine (WHO, 2022b). Even Rohingya children and adolescents started to receive the COVID vaccination from June 2022 (UNHCR, 2022c). As of December 2022, in the Cox's Bazar Rohingya refugee camps, 90% of the target population (≥12 years) completed their full course (two doses) of the COVID-19 vaccine and 86% of the eligible population (≥12 years) had received a booster dose (third dose) of the COVID-19 vaccine (WHO, 2022a). The Rohingya refugees got the COVID

vaccination through the National Deployment and Vaccination Plan of the GoB with support of UNHCR, WHO, UNICEF and other humanitarian partners (UNHCR, 2022c). Mary et al. (2023) observed that by the end of 2022, Bangladesh had achieved herd immunity against COVID-19 by vaccinating 70% of its population including Rohingya refugees.

3.8.3 (b) Cholera/Diarrhoea

Poor infrastructure, poor sanitation and inadequate drainage systems in the camps place the Rohingyas at increased risk for water-borne diseases, such as cholera and diarrhoea. Phares and Ortega (2014) have mentioned that the risk of cholera or diarrhoea is often amplified in refugee communities as they flee from their home countries under precarious conditions with limited public health safeguards. The incredibly high population density in the Rohingya camps of Bangladesh and high levels of severe malnutrition among Rohingya children increased the risks associated with an outbreak of acute watery diarrhoea and cholera in 2017 (Riley et al., 2017). Inadequate sanitation facilities, the lack of safe and adequate water supplies, contamination of water, congested and unhygienic living condition are the main causes of watery diarrhoea among the Rohingya refugees in Bangladesh (Akhter et al., 2020).

In October 2017, the Bangladeshi authorities reported 10,247 cases of diarrhoea among the newly entered Rohingyas, although the UNHCR asserted that the real incidence at that time was much higher (UNHCR, 2017). The GoB considered water-borne diarrhoea or cholera as a potential epidemic disaster and conducted cholera vaccination campaigns in the camps with the support of WHO, UNICEF, and other partners. The first mass oral cholera vaccination (OCV) campaign targeting all persons aged ≥1 year was conducted among the Rohingya refugees during October and November of 2017 (Summers et al., 2017). Up to December

2022, the authorities had conducted seven rounds of OCV campaigns among the Rohingya refugee population; these were in the months of October and November in 2017, May and December in 2018, December in 2019, and October and November in 2022 (MoHFW, 2023). These dates indicate that a cholera vaccination campaign goes on every year in the Rohingya camps. Still, the cramped and crowded conditions, inadequate sanitation, and poor infrastructure of the camps put the Rohingyas at the risk of cholera or diarrhoea outbreak.

Other waterborne diseases

Besides diarrhoea or cholera, other waterborne diseases, such as typhoid and hepatitis E, also pose great risks in the congested Rohingya refugee camps. Akhter et al. (2020) and Islam and Nuzhath (2018) commented that the prevalence of waterborne and other infectious diseases was still exceptionally high in the Rohingya camps due to the refugees' unhygienic living conditions.

3.8.3 (c) Diphtheria

Diphtheria is a serious infection caused by a strain of bacteria called *Corynebacterium diphtheriae.* Initially in 2017 and then in 2018, diphtheria was the major problem for the Rohingya refugees (See Table 2). Alam et al. (2019) and Rahman and Islam (2019) noted that, in November 2017, an outbreak of diphtheria was first identified in the Kutupalong Rohingya camp. This outbreak spread quickly and became a major public health threat, which was an emergency within an emergency. MSF (2017) revealed that, although diphtheria had been forgotten in most parts of the world due to the increasing rates of vaccination, it re-emerged in the Cox's Bazar Rohingya camps at the end of 2017. Similarly,

Yasmin and Akther (2020) observed that diphtheria had not been reported in Bangladesh for the last 35 years but was found among the newly entered Rohingya people in 2017. Blumberg et al. (2018) described the diphtheria outbreak in the Rohingya refugee community as the "the preventable tragedy of diphtheria in the 21st century (p. 1)."

Table 2: Diphtheria snapshot (WHO, Epidemiological Highlights, 2023)

Classification	2017	2018	2019	2020	2021	2022
Confirmed	66	226	31	19	30	56
Probable	1154	1555	60	9	29	3
Suspected	1796	3549	523	198	118	349
Deaths	30	14	3	0	5	2

Source: https://cdn.who.int/media/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/ewars/2023/ewars-w29-2023.pdf?sfvrsn=3759365b_1&download=true

To address the problem, the government of Bangladesh, with the support of UNICEF, the World Health Organisation (WHO) and GAVI (Global Alliance for Vaccines and Immunization), launched a massive diphtheria vaccination campaign and successfully contained it. Three rounds of diphtheria vaccination campaigns were carried out in the refugee camps during December 2017; January–February 2018; and March 2018 targeting children under 15 years of age (Rahman & Islam, 2019). Now every year diphtheria vaccination campaigns are conducted among the Rohingya children living in the camp (Ahmed et al. 2023). As diphtheria is typically spread via respiratory droplets from coughing and sneezing, Rohingya refugee camps are still at high risk of diphtheria due to a lack of access to a vaccine booster and the congested living environment. Moreover, the problem has been exacerbated by the fact that the immunity of the human body to diphtheria decreases

every five years after the initial vaccination (De Celles et al., 2019). Thus, the Rohingya population remains almost constantly vulnerable to this disease.

3.8.3 (d) Measles

Measles or rubeola is a highly contagious viral disease caused by a virus from the paramyxovirus family. Measles broke out in the Rohingya refugee camps during the December 2017-April 2018 period, with over 2,500 cases. Perhaps one of the causes of this outbreak was the low rate of measles immunisation among the Rohingya population (Chin et al., 2020). A retrospective survey conducted by MSF estimated measles vaccination coverage among the Rohingya children aged 6 to 59 months was less than 25% during the arrival of Rohingyas in 2017 (Grellety & Falq, 2017). Over 1700 measles cases occurred among the Rohingyas in three months between September and November 2017 (Chin et al., 2020). Measles is predominantly dangerous for children, putting them at risk of severe pneumonia, encephalitis, and death. Chan et al. (2018) mentioned that 82% of measles cases occurred in Rohingya children of under 5 years of age.

Measles is a preventable disease; a simple and safe vaccination protects against the illness. However, the Rohingya children were unprotected against measles when they entered into Bangladesh (MSF, 2020c). The Bangladeshi authorities conducted two measles-rubella (MR) vaccination campaigns in 2017 in the Rohingya refugee camps to curb the transmission (Mair et al., 2020). The first campaign, which ran from September 16 to October 3, administered the MR vaccine to 135,519 Rohingya children aged between 6 months and 15 years (WHO, 2017b). The second campaign ran from November 18 to December 5 to vaccinate 354,982 children of the same age group (MoHFW, 2023). In 2020, a third MR vaccination campaign

ran from January 12 to February 12 to administer vaccines to 292,394 Rohingya children (MoHFW, 2023). The UNHCR observed that diphtheria and measles outbreak in November 2017 could have killed many more Rohingya people had no swift action been taken (Sida et al., 2018). In Bangladesh Rohingya refugee camps the routine immunisation including EPI (Expanded Programme on Immunisation) has been conducted regularly among the Rohingya kids to protect them from various communicable diseases (Al Amin, 2022).

3.8.3 (e) Mumps

Mumps is a contagious disease caused by a mumps (paramyxo) virus. It usually infects children, although anyone of any age can catch mumps. It commonly causes fever, tiredness, and swelling of the salivary glands in the face; but it can also affect other organs. Some cases of mumps may lead to complications that have lifelong effects, such as hearing loss and infertility. Mumps is common in Bangladesh as well as in the Rohingya refugee camps of Cox's Bazar. A large epidemic of mumps occurred in the Rohingya refugee camps in 2018 with 19,215 cases reported from January to December. Of the infected cases, 40% were children less than 5 years old (Mair et al., 2020).

In the Rohingya refugee camps, the mumps epidemic occurred along with the diphtheria outbreak. The most common reported symptoms of diphtheria are fever, sore throat, and difficulty in swallowing. These symptoms are also common in patients with mumps. As mentioned earlier, the authorities ran measles-rubella (MR) vaccination campaigns in the Rohingya camps in 2017 and 2020 but no mumps vaccine was administered (Mair et al., 2020). Usually, measles-mumps-rubella (MMR) vaccines are administered together in vaccination campaigns throughout the world. However, in Bangladesh under EPI, only

measles-rubella (MR) vaccines are administered (Mair et al., 2020). In the case of the Rohingya camps, too, the Bangladeshi authorities and development partners decided to provide MR vaccines to the refugees instead of MMR vaccines.

3.8.3 (f) HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a chronic, potentially life-threatening condition caused by the Human Immunodeficiency Virus (HIV). An HIV/AIDS outbreak was also feared among Rohingya entrants to Bangladesh in 2017. Bangladesh and Myanmar have a low prevalence of HIV/AIDS among South Asian countries but the Rakhine state of Myanmar, from which the Rohingyas originate, had the highest prevalence of HIV/AIDS in 2015 (Islam & Nuzhath, 2018). Rohingya women and children had been victims of gang-rape and other sexual abuses in Myanmar, increasing the risk of exposure to HIV and other sexually transmitted diseases (STDs) (Ainul et al., 2018). The extent of sexual oppression of these groups in the camps is also very high. Thus, Rohingya refugees have become highly vulnerable to HIV/AIDS due to the high prevalence of AIDS in Rakhine and high possibility of sexual contracts in the Bangladeshi camps (Hsan et al., 2019). Public health experts say a lack of awareness about sexually transmitted infections and social stigma still persists in the Rohingya camps, which in turn contributes to the rising HIV and other sexual infections among Rohingya refugees (Karmakar, 2018; Rafe, 2019).

Soon after the arrival of Rohingyas in Bangladesh at the end of 2017, health authorities carried out diagnostic tests and identified 85 cases of HIV/AIDS (Khan et al. 2021a). Since then, the number of HIV/AIDS patients has risen steadily in the Rohingya refugee camps: there were 273 patients in August 2018, 319 in March 2019 and 395 in December 2019

(Khan et al., 2021a). As of June 2022, out of the total 958 HIV/AIDS patients in Cox's Bazar area, 771 were Rohingyas (TBS Report, 2022). However, this number is unlikely to represent the true prevalence of the disease in the Rohingya refugee camps as many HIV/AIDS cases remain undiagnosed and asymptomatic. The Rohingyas are not particularly interested in diagnosing the disease. Khan et al. (2021a) mentioned various reasons for higher cases of HIV/AIDS in the refugee camps, such as gender-based violence (GBV), inadequate knowledge of STDs, child marriages, unsafe sexual practices including polygamy and sex outside marriage, and the lack of access to diagnosis of and treatment facilities for STDs. The border district of Cox's Bazar is infamous for drug trafficking. Thus, the Rohingya refugee population are at a high risk of drug abuse and vulnerable to HIV/AIDS (Hsan et al., 2019).

Other sexually transmitted diseases

Sexually transmitted diseases (STDs) are caused by bacteria, viruses or parasites that are transmitted through unprotected sex (vaginal, anal, or oral) and skin-to-skin genital contact. Besides HIV/AIDS, Rohingya refugees are also at a higher risk for contracting other sexually transmitted infections (STIs), such as syphilis, gonorrhoea, and chlamydia due to the lack of basic living facilities, lack of access to protection and/or treatment, and drug trafficking in the camps (Rafe, 2019). Silveira (2017) observed that during a humanitarian response, traditional priorities tend to focus on provision of shelter, food, water, sanitation, and basic health services, but little attention has been paid to sexually transmitted infections (STIs). Hossain et al. (2018) observed that the prevalence of sexually transmitted infections was high among Rohingya refugees due to gender-based violence against Rohingya girls and women, and drug-trafficking. Experts said a lack of awareness about sexually transmitted infections

(STIs) and social stigma against these infectious diseases were the barriers to preventing the spread of these diseases in the Bangladeshi camps.

3.8.3 (g) Tuberculosis

Tuberculosis (TB) is a dangerous bacterial infection caused by *Mycobacterium Tuberculosis* that affects the lungs. It spreads when an infected person coughs, sneezes, or talks. Although there is no mechanism yet in place to detect the TB cases in the Rohingya camps, health observers anticipated a high prevalence of TB cases among Rohingya refugees due to poor living conditions (Joarder et al., 2020; Zaman, 2023). Bangladesh and Myanmar belong to the list of top 30 countries with a high TB infection rate (Yazdani, 2022). Boyd and Cookson (2019) stated that the Rohingya crisis in Bangladesh was likely to present a high TB burden to Bangladesh although this disease is highly non-specific and mimics other diseases. Jasmine et al. (2020) found that the incidence of TB cases in the Rohingya community was relatively high, owing to malnutrition, poor living conditions, and a general lack of knowledge about the disease.

Tuberculosis is a major public health concern amongst the Rohingya refugees primarily due to the high risk of transmission and rapid progression of the disease (Perrelle et al., 2018). In 2017, the World Health Organisation warned that an outbreak of tuberculosis among the Rohingya refugees would also be a threat to the locals (Jasmine et al. 2020). In Bangladesh, the National TB Control Programme (NTP) works in early diagnosis for unreached populations and provides appropriate treatment to TB patients (WHO, 2021b). In the Rohingya refugee camps, NTP and BRAC health workers have been screening TB patients since October 2020 under a large-scale detection program utilising latest-mobile vans

equipped with digital X-ray and GeneXpert machines (Yazdani, 2022). Currently, ten tuberculosis testing labs and two mobile vans are operating in the 33 Rohingya camps. Yazdani (2022) also observed that BRAC's mobile van tuberculosis team were working as a driving force to combat tuberculosis among the Rohingya community in the refugee camps.

3.8.3 (h) Hepatitis

Hepatitis virus (HV) infections are a severe health concern worldwide. Hepatitis is a general term used to describe inflammation of the liver. Hepatitis may be caused by drugs, alcohol use, or certain medical conditions but in most cases, it is caused by a virus, which is known as viral hepatitis. The most common forms are Hepatitis A, B, C, D and E. The symptoms of hepatitis may include fatigue, nausea, poor appetite, belly pain, a mild fever, or yellow skin or eyes (jaundice). Hepatitis A and B are vaccine preventable but there is no vaccine available for Hepatitis C, D and E. Once hepatitis develops in a patient, there is no full cure for the condition. Treatment focuses on preventing further damage to the liver, reversing existing damage, if possible, and relieving the symptoms.

Hepatitis B (HBV) and C viruses (HCV) are the most prevalent among the Bangladeshi population. The prevalence of these viruses is ten times higher among Rohingya refugees than Bangladeshis (Mahtab et al., 2019). A study on the prevalence of Hepatitis B and C virus among the Rohingya refugees in Cox's Bazar found that more than one in five adults had HCV infection (Ali et al., 2022). The National Liver Foundation of Bangladesh (NLFB), a philanthropic organisation dedicated to preventing, treating, and sharing knowledge on hepatitis, conducted two studies on the prevalence of HBV and HCV among the Rohingya

refugees in 2017 and 2019 (Ali et al., 2022). Among all age groups, HCV was found in 11% of the Rohingya people, and HBV in 4% (Jahan, 2022).

3.8.3 (i) Skin disease

The skin is the largest organ of human body, covering and protecting it. A skin disease is any disease or disorder that affects the human skin. Skin diseases vary greatly in symptoms and severity and can be temporary or permanent. Skin diseases can be caused by infection (bacterial, viral, or fungal), allergies, autoimmune reactions, parasites, or cancers. The Rohingya refugees, currently living in the overcrowded camps of Cox's Bazar with poor living conditions, encounter various skin diseases (Islam et al., 2019). The rate of skin infections among Rohingya refugees in Cox's Bazar has risen in the past five years (2017-2021). The incidence of skin diseases among the Rohingya refugees doubled from 2019 to 2021 (MSF, 2022a). WHO observed that the number of skin infection consultations among the Rohingyas in Bangladesh had increased by 1.8 times from 2019 to 2022. The number of skin infection consultation was 45% higher in 2021 than in 2020 (WHO, 2022c). In 2023, an outbreak of scabies, a skin disease, occurred in the Rohingya camps of Bangladesh (MSF, 2023b).

MSF reported that, in the middle of 2022, scabies was on the rise among Rohingyas in the Cox's Bazar camps (MSF, 2022a). In 2023, WHO observed 40% of Rohingya people in the overcrowded camps have scabies, with up to 70% in some camps (WHO, 2023a; Thornton, 2023). Scabies is an itchy skin disease caused by a tiny burrowing mite known as Sarcoptes scabiei. Scabies is not an infection, but an infestation where the mites burrow and lay eggs in the skin, causing rashes and sores. Skin-to-skin transmission occurs when infested and fresh

bodies come into contact through clothes and furnishings. The scabies infestation is treatable. Its rapid spread among the Rohingyas in 2022 highlights the severe overcrowding condition of the refugee camps and lack of adequate medication, water, and sanitation facilities (Anik, 2022). Scabies shows an average of 10.2% prevalence rate in the Rohingya refugee camps (WHO, 2022d). Due to this high prevalence rate, scabies emerged as a new and important public health concern among the Rohingya refugees.

3.8.3 (j) Dengue and other mosquito-borne diseases

Mosquito-borne diseases are those spread by the bite of an infected mosquito. These diseases include dengue, chikungunya, and malaria. Mosquitos are small, blood-sucking insects that may carry germs like viruses, which would spread to a person through a bite. These tiny insects can be found allover the world and cause various diseases including those mentioned above. Mosquito-borne diseases are not contagious, i.e., they do not spread from person to person; mosquitoes are the carriers of these diseases. Common signs and symptoms of mosquito-borne diseases include mild fever, headache, body aches, nausea, vomiting and a rash. However, severe illness could occur if the virus carried by mosquitoes affects the membranes of the brain and spinal cord (meningitis) or the brain itself (encephalitis).

According to the WHO, use of long-lasting insecticidal nets (LLINs) or mosquito nets is recommended for people living in areas at risk of mosquito-borne diseases. Besides the use of mosquito nets, effective behaviour change is needed to ensure that people use the nets every night, and that they maintain them properly (WHO, 2018b).

Dengue

Dengue, a mosquito-borne disease, is common among the Rohingya refugees living in Bangladesh. Dengue virus is transmitted to humans through the bites of infected female mosquitoes from primarily the Aedes Aegypti genus. Bangladesh, a tropical country, experiences dengue outbreaks every year due to its high population density, unplanned urbanisation, hot and humid climate, and heavy rainfall during the monsoon season (Patwary et al., 2022). The Rohingya camps in Bangladesh also experience a high prevalence of dengue. The infection rate of dengue disease in the Rohingya refugee camps increased during the 2018-2022 period. In 2022, a total of 15,373 confirmed cases of dengue and 23 deaths among the Rohingyas were reported (WHO, 2023b). Dengue does not have any specific treatment or widely available vaccine. Thus, avoiding mosquito bites is an important measure to prevent its spread. As mentioned earlier, people use mosquito nets at night to prevent getting bitten. However, the Rohingya refugees are in constant danger of getting dengue as mosquito nets are scarce in the camps.

In 2023, Bangladesh witnessed the deadliest outbreak of dengue fever ever since its first outbreak in the country in 2000 (Paul, 2023). Up to October 2023, more than 1,000 people have already died from Dengue fever in Bangladesh and more than 200,000 infected (Basu, 2023). Rohingya Camps have also recorded a cyclic and recurrent upsurge of dengue fever like other parts of Bangladesh. At 33 camps of Cox's Bazar, Bangladesh, from 1 January to 12 August 2023, the confirmed number of dengue cases is 6,127 with six deaths (WHO, 2023b). Bangladesh as a country is struggling to face the dengue epidemic scenario in 2023 as hospitals are hard put to find space for the large number of dengue patients (Basu, 2023).

Malaria

Malaria is a serious and sometimes life-threatening tropical disease that is caused by Plasmodium parasites and spreads through mosquitoes. Only female anopheles mosquitoes spread the malaria parasites. In Bangladesh, the three hill track districts – Bandarban, Khagrachari, and Rangamati – report the highest malaria cases and deaths every year. These districts are followed by the district of Cox's Bazar, where the Rohingyas live in the camps (Sharma & Singh, 2021). The overcrowded camps of Cox's Bazar, with suboptimal sanitation facilities and poor sewage disposal, have an increased risk of malaria. There is no specific study on the malaria prevalence and transmission dynamics in the Rohingya refugee settlements of Bangladesh. Lu et al. (2018) found no cases of malaria among the Rohingya children of three refugee settlements of Cox's Bazar. However, during the rainy season, water bodies inside the camps become breeding grounds for mosquitoes, which in turn increases the risk of malaria among the Rohingya people.

Besides dengue and malaria, other mosquito-borne disease, such as chikungunya, may also affect the Rohingya population of Bangladesh.

3.8.4 Non- Communicable Diseases

A noncommunicable disease (NCD) cannot be transmitted from person to person. It is generally caused by individual or environmental behaviour. So, non-communicable diseases can be defined as non-infectious and non-transmissible medical conditions such as cardiovascular diseases, diabetes, anaemia, cancer, dental and musculoskeletal problems,

chronic kidney and lung disease. Non-communicable diseases can be life-threatening if left untreated. So far, there is no study specifically to estimate the prevalence of non-communicable diseases (NCDs) among Rohingya refugees in Bangladesh. In March 2018, the BRAC (an international development organisation based in Bangladesh) conducted a needs assessment and reported that about 51.5% people living in the Rohingya camps had hypertension and 14.2% had diabetes (Joarder et al., 2020).

According to the WHO, hypertension is the highest prevalent NCD among the Rohingyas in Bangladesh with a rate of 34%, followed by diabetes mellitus (33%), chronic obstructive pulmonary disease (9%), asthma (7%), cardiovascular disease (1%), and other NCDs/chronic conditions (16%) (WHO, 2022e). Due to poor sanitation, crowded living conditions, and insufficient foods, Rohingya refugees are highly vulnerable to non-communicable diseases (Jubayer et al., 2021). Besides the shock of earlier-mentioned sexual violence, factors including physical idleness, unhealthy lifestyles, and little or no knowledge of NCD make the Rohingya community more vulnerable to non-communicable diseases. Kumar et al. (2022) observed that in the aftermath of the COVID -19 pandemic the severity of non-communicable diseases in the Rohingya camps had been increasing and had become challenging.

3.8.5 Child Health

In Rohingya refugee camps, children make up around 52% of the population (HRW, 2022). Critics have no doubt about the magnitude of health concerns of Rohingya children in these camps (Hossain et al., 2019). According to the WHO, 32% of Rohingya refugee children have acute respiratory infections (ARIs) and 27% suffer from unexplained fever ((Joarder et al., 2020). Cases of acute watery diarrhoea, skin diseases, injuries, eye infections, and malaria

were also found among Rohingya refugee children (Joarder et al., 2020). Although the malnutrition rate among Rohingya children has dropped from 19% to 11%, the prevalence of anaemia in children aged 6–23 months was more than 50% and stunting among children aged 0–59 months remains a serious concern (Hossain et al., 2019). The U.N. observed that 40% of Rohingya children had endured stunted growth, and more than half of them suffered from anaemia (OHCHR, 2023).

Many Rohingya children living in the refugee camps of Bangladesh have either lost or been separated from their parents. The number of children without parents is growing. These children have been exposed to trauma due to prolonged neglect or abuse, poverty, and hunger in the camps affecting their mental health. A study mentioned that one in five Rohingya child refugees suffers from severe mental health issues (Grunebaum, 2019b; Save the Children, 2018). In 2021, Save the Children, an international organisation working for the welfare of children, reported that Rohingya children were still showing visible signs of distress including sleeplessness, nightmares, depression, and self-harm (Save the Children, 2021). More than 100, 000 newborn babies, who are growing up in a subhuman condition without proper healthcare and education, were added to the Rohingya population in the five years after the 2017 exodus (Kamruzzaman, 2022).

3.8.6 Women's Health

Rohingya women and girls are the survivors of rampant sexual violence in Myanmar before they sought refuge in Bangladesh in late 2017. In Cox's Bazar camps, women and girls are the most vulnerable groups without proper healthcare facilities and services. Ahmed et al. (2019) observed that more than half of the Rohingya refugees are women and girls who are in

need of quality sexual and reproductive health (SRH) services. In 1994, sexual and reproductive health (SRH) of displaced populations were declared human rights (Black et al., 2014). However, poor SRH services in Rohingya refugee camps contribute to maternal mortality and morbidity, various reproductive tract infections, and sexually transmitted diseases, such as HIV/AIDS (Jeffries et al., 2021). In the refugee camps of Bangladesh, 52 maternal deaths were reported between September 2017 and August 2018 (Parmar et al., 2019). These preventable deaths occurred partly due to the poor sanitation and unhygienic environment of the Rohingya refugee camps. Rohingya women suffer at every stage of their sexual and reproductive health (Joarder et al., 2020).

Fetters et al. (2020) observed that, many Rohingya women and girls fled homes and communities in 2017, experiencing terrible violence, and arrived at the Cox's Bazar camps in Bangladesh with sexual and reproductive health needs, including unwanted pregnancies and a demand for abortion. These needs still exist among the Rohingya refugees. Arie (2019) mentioned that 60 babies are born in the camps every day and many Rohingya women need emergency healthcare services. Chowdhury et al. (2018) have suggested that special attention should be paid to pregnancy, lactation, family planning, and health status of children under five of the Rohingya population. Ainul et al. (2018) observed that access to sexual and reproductive health information and services is a critical issue for women and adolescents living in the Cox's Bazar camps. Metusela et al. (2017) indicated that sexual and reproductive health (SRH) is shaped by socio-cultural factors, which can act as barriers to knowledge and influence access to healthcare for any refugee women.

As per UNFPA's June 2018 situation report, there were 316,000 women of reproductive and 63,700 pregnant women in the Rohingya camps. These figures are indicative of the extent of

gender-based violence, and also of the grave health risks faced by women in the camps (Huang & Schnabel, 2018; Hossain & Dawson, 2021). Joarder et al. (2020) mentioned that a significant number of pregnant Rohingya women could not receive proper antenatal care (ANC) as the services are either unavailable or inaccessible in the refugee camp area. Many sexual and reproductive health (SRH) centres in the Rohingya camps have limited facilities for essential antenatal care (ANC) components, such as blood testing, urine testing, and tetanus vaccination (Joarder et al., 2020). Jannat et al. (2022) observed that Rohingya women who deliver children born of rape often experience the added trauma of being shamed and stigmatised, and those who contact HIV or other sexually transmitted infections face social marginalisation. In 2018, Oxfam issued a warning that Rohingya women living in Bangladesh were developing health issues, missing out on aid, and were generally at greater risk of abuse due to unsuitable and unsafe living conditions in most of the Rohingya refugee camps (Oxfam, 2018). Another issue, which affects the Rohingya women health in the long run, is the limited use of contraception in the refugee camps (Azad et al., 2022; Jannat et al., 2022).

3.8.7 Mental Health

Unlike physical health issues, mental health issues of Rohingya refugees do not attract much attention. The scarcity of evidence on mental health issues of Rohingya refugees living in Bangladesh is a testament to this lack. Only a handful of studies could be identified in this specific area. Kaur et al. (2020) stated that psychological or mental health disorders (MHDs) had been recognised as major public health issues among the Rohingya refugees living in the Cox's Bazar camps. One study mentioned that 61% of Rohingya refugees are still suffering from post-traumatic stress disorder (PTSD) and 84% endorse a high level of emotional

distress, such as symptoms of anxiety and depression (Riley et al., 2020). Symptoms of depression and suicidal thoughts are also prevalent in the Rohingya community (Riley et al., 2017). Female Rohingya adults and children experience mental stress as they have no personal security while using shared toilets with males and no private space in their tents for sleeping, bathing, or changing their clothes (Joarder et al., 2020). A 2022 study of 6,906 Rohingyas in Cox's Bazar revealed that one in three Rohingya adults experienced symptoms consistent with depression and nearly 5% experienced symptoms consistent with PTSD (Ritsema & Armstrong-Hough, 2022).

Tay et al. (2018) reported that at least 50% of the Rohingya refugee children in the camps always felt sad, tense, or nervous, and more than 60% of adults were always sad and tense. Guglielmi et al. (2019) observed that 14% of Rohingya adolescents suffer from psychological distress. Riley et al. (2017) found that the most common MHDs affecting Rohingya refugees were major depressive disorder (MDD), followed by post-traumatic stress disorder (PTSD), and generalised anxiety disorder (GAD). Hossain & Purohit (2018) asserted that the outbreak of physical diseases, such as diphtheria, cholera, and measles, represented only a small part of the problem; a more concerning challenge was to protect the mental health of Rohingyas exposed to genocide and humanitarian crises. Palit et al. (2022) found that there was a significant deterioration of mental health of Rohingya refugees during the COVID-19 pandemic.

The multiple and chronic stresses of everyday life at the camps including poor living conditions, dependency on food assistance, domestic violence, safety and protection issues, lack of social and leisure opportunities, rupture of social and emotional links due to the migration process, and COVID -19, add to the traumatic experiences of the Rohingya people

(Riley et al. 2017). Christensen et al. (2020) and Riley et al. (2020) revealed that high levels of current daily stressors among the Rohingya population were due to lack of adequate income, insufficient food, limited access to education, and limited freedom of movement. The main concern of the mental health of Rohingya refugees was, and still is, the uncertainty about their future (Ullah et al., 2023). In fact, Rohingyas' lives in the camps are on hold with a traumatic past, diabolical present, and an uncertain future.

3.8.8 Low Health Literacy of Rohingyas

Without citizenship rights or refugee status, the Rohingyas were deprived of education in Myanmar and Bangladeshi camps respectively. The Rohingyas have not been allowed to receive any formal education in their life since 1962, which has resulted a high rate of illiteracy among the Rohingyas. A 2019 study mentioned that 97% of the adolescents and youth (15-24 years of age) of Rohingya refugees in the Bangladeshi camps lack access to any type of formal education (UNICEF, 2019). Their overall poor health knowledge, a consequence of the lack of education, acts as a barrier to receiving health services. Rahman et al. (2020) found that the Rohingya refugees had poor health literacy, which adversely affected their health status. In December 2017, an MSF health survey in the Rohingya camps found that 49% of Rohingya people who reported being ill said they had not visited a health facility; 9% said they did not access any form of healthcare; and 37% reported self-medicating (Bark et al., 2018).

3.9 Disease Detection/Monitoring Measures at the camps

Regular health surveillance is a requirement for monitoring refugee health status and for responding in a timely manner to any public health emergencies. Immediately after the arrival of the Rohingya refugees in Bangladesh in 2017, the Bangladeshi Ministry of Health and Family Welfare (MoHFW) and World Health Organisation (WHO) established the Global Outbreak Alert and Response Network (GOARN) team consisting of epidemiologists, vaccine specialists, and technical experts (Karin et al., 2020). The objective of the GOARN team was to deliver technical assistance to build capacity at the local level for better prevention and control of outbreaks among the Rohingya refugees (Alam et al., 2019). The GOARN team contributed to the establishment of the Early Warning, Alert and Response System (EWARS) for detection of diseases. The EWARS still works today to monitor the health or disease status of the Rohingyas living in the Cox's Bazar camps.

3.9.1 Global Outbreak Alert and Response Network (GOARN)

The Global Outbreak Alert and Response Network (GOARN) was established in 2000 as a network of technical and research institutes, universities, international health organisations and technical networks that would work for the coordination of international outbreak response (Mackenzie et al., 2014). The GOARN partners agreed that the World Health Organisation would coordinate the network and provide a secretariat, which would also function as the operational support team. After the resettlement of Rohingya refugees in Bangladesh in August 2017, a diphtheria outbreak hit the Rohingya camps in November with 440 reported cases. Then WHO deployed its GOARN team, consisted of epidemiologists, vaccine specialists, and technical experts. This team's primary responsibility was to contain

the diphtheria outbreak and prevent any additional outbreaks (Alam et al., 2019; Karin, 2020).

The overall objective of the GOARN team was to provide technical support for capacity building and training of health professionals for improved prevention and control of any further outbreaks (Alam et al., 2019). The GOARN team worked with MoHFW and other health organisations to establish a monitoring system for diphtheria and other infectious diseases in the Rohingya camps and in the host community of Cox's Bazar. The GOARN team also contributed to the establishment and monitoring of EWARS (Karin et al. 2020). Alam et al. (2019) observed that the main contributions of the GOARN team included:

1) supporting the establishment and monitoring of the Early Warning, Alert and Response System (EWARS) for diphtheria and other infectious diseases;
2) coordinating contact tracing within the camps and the host community of Cox's Bazar;
3) organising the establishment of local laboratory capacity for diphtheria and other epidemic-prone diseases; and
4) providing infection prevention and control assessment, training, and support to the local health professionals with a focus on anticipated potential health needs.

3.9.2 Early Warning, Alert and Response System (EWARS)

Developed by WHO in 2015, the Early Warning, Alert and Response System (EWARS) is a web-based system and mobile application for outbreak detection and response in any emergency setting (Karo et al., 2018). Since the exodus of Rohingyas to Bangladesh in August 2017, the World Health Organisation, in partnership with the Bangladeshi Ministry of

Health and Family Welfare and with the assistance of the GOARN team, has implemented the Early Warning, Alert and Response System (EWARS) across the Rohingya camps to detect disease outbreak (Karo et al., 2018; Mair et al., 2020; Wijekoon et al., 2020). EWARS has been designed to provide timely information on epidemic-potential diseases among all the Rohingya refugees of Bangladesh (Hussain-Alkhateeb et al., 2018; Karo et al., 2018). While the target of EWARS was the Rohingya refugee communities when it was established, the system now works for both the Rohingya refugees and host communities of Cox's Bazar (WHO, 2018c).

EWARS, established in October and upgraded in December 2017, has been the main source of information about the status of the outbreak-prone infectious diseases among the Rohingya refugees living in 33 makeshift camps of Cox's Bazar (WHO, 2018a). The EWARS monitors the communicable/infectious diseases or syndromes that affect the Rohingya refugees, including diphtheria, acute respiratory infection (ARI), acute watery diarrhoea (AWD), bloody diarrhoea, measles/rubella, acute flaccid paralysis (AFP), suspected meningitis, acute jaundice syndrome (AJS), acute haemorrhagic fever, neonatal and adult tetanus, confirmed and suspected malaria, and unexplained fever (WHO, 2018a). EWARS issues dozens of diseases alerts each week based on information from the health facilities inside and outside the Cox's Bazar camps. The EWARS team reviews, verifies, and assesses each alert and, if more evidence is needed, sends a separate team to investigate further (WHO, 2018c).

3.10 Health Negotiations at the Camps

The Rohingyas, living in the 33 makeshifts camps of Bangladesh, are completely dependent on the aid supply. The GoB and its local and international partners work to provide the Rohingya refugees with shelter, education, food, and essential items. These include compressed rice husk as cooking fuel, LPG gas cylinders, lentils, oil, as well as daily essentials including soap, clothing, blankets, sleeping mats, jerry cans, WASH (Water, Sanitation and Hygiene) kits and dignity kits (Banerjee, 2019). However, the Rohingyas are strictly confined to the camps; they are not allowed to leave the camps without official permission.

When the Rohingyas encounter any health problems, their first port of call is one of the primary healthcare centres (PHC) in the camps. These centres are also known as refugee health unit (RHU). All treatment, medications and diagnostic tests at the health centres are free of cost for the Rohingya refugees (Rahman et al., 2020). Some over the counter (OTC) medicines are also available at pharmacy shops and groceries around the camps. The camp dwellers can purchase medicines from these establishments, if needed, utilising their personal funds. Rohingya patients requiring secondary and tertiary health care are transferred to local government hospitals or medical college hospitals in Cox's Bazar district town and Chittagong city (Rahman et al., 2020). A 24/7 ambulance service is also available through a medical referral for transporting critically ill Rohingya refugees to hospital services outside the refugee settlements (UNHCR, 2019c).

For any health needs, the Rohingya refugees can talk to the community health workers (CHWs) working in the camp area. More than 1,000 trained community health workers (CHWs), mostly Rohingya refugees, are continuously reaching out to their communities to

raise awareness on various health issues, such as new-born care for new mothers and infectious disease prevention, identifying health cases and providing referrals to appropriate services (Rahman & Yeasmine, 2020). These community health workers act as a bridge between the Rohingya refugee communities and health facilities at the camps; they also lead the battle against COVID-19 at the camps (Rahman & Yeasmine, 2020).

The living conditions in the Rohingya refugee camps of Cox's Bazar are woefully inadequate and unhealthy (Khan et al., 2020). As a result, the Rohingya camps are burdened with many infectious diseases, such as respiratory tract infections, diarrhoea, measles, diphtheria, HIV/AIDS, and TB (Joarder et al., 2020; Kamal et al., 2020). Non-communicable diseases, such as hypertension and diabetes, are also highly prevalent among the Rohingyas (Joarder et al., 2020). The congested, overcrowded, and unhygienic conditions of Rohingya camps are conducive for many contagious diseases, including skin and respiratory infections. In the Rohingya settlements, malnutrition is still a health risk although significant improvements have been achieved in both acute and micronutrient malnutrition among Rohingya children (Al Fidah et al., 2023; Leidman et al., 2020).

In addition, some gender-specific risks at the camps work as a barrier to receiving health services for Rohingya women. The Rohingyas are a culturally conservative community; women and teenage girls are expected to stay at home and be homemakers (Wali et al., 2018). They lack control over household finances; their dependence on male relatives makes them vulnerable to assault, domestic violence, child marriage, exploitation, and trafficking. Social and cultural norms, such as the 'purdah system', prevent Rohingya women from going outside to use toilets. Even when they can go outside, the inadequate infrastructure-to-people

ratio in the camps causes long queues, which includes men, and make it difficult for women to use the toilets (Banerjee, 2019).

The Rohingya refugees tackled the COVID-19 pandemic with limited health infrastructure and shared sanitary facilities. When the first case of COVID-19 was confirmed in the refugee camps in mid-May 2020, there was an increased sense of fear and alarm among the Rohingya people (Jean, 2020). Rumours spread in the Rohingya camps that if anyone had COVID-19, they must be killed to prevent others from getting infected (Islam & Yunus, 2020). The Bangladeshi government and international development agencies fought against the rumours and managed the COVID-19 situation in the camps by creating awareness among the Rohingyas, establishing isolation centres, and creating a conducive environment for the active participation of the Rohingya community (Brown, 2020).

3.11 Overall Health Scenario after 6 years of 2017 Rohingya Exodus

In the last six years, the Bangladeshi government, its UN partners, and other stakeholders have been trying to ensure the Rohingyas' lifesaving needs including health services, but daunting challenges persist (IOM, 2020; MSF, 2022b; MSF, 2023a). During these years, some improvements have been observed, but the overall health scenario in the camps continues to be dire. The miserable living conditions in the Rohingya camps, alongside the lack of livelihood opportunities and access to basic needs, had been exacerbated by the COVID-19 pandemic (MedGlobal, 2022; Palattiyil et al., 2023). The COVID-19 pandemic changed the priorities in the Rohingya refugee camps, with stakeholders putting more emphasis on COVID-19 prevention and treatment rather than other health issues, which

significantly increased Rohingyas' vulnerability to poor health outcomes (Halder et al., 2023; Hossain & Zablotska-Manos, 2021).

In the Rohingya camps, the mortality rate has decreased since 2017 and is currently well below the emergency thresholds (standard emergency threshold is 1 death/10,000/day) (Truelove et al., 2020). However, neonatal mortality in the Rohingya community is 27.0 per 1,000 live births which is higher than the national estimate of Bangladesh (17.0 per 1000 live births) (Amsalu et al, 2022). The mental health needs of the Rohingya refugees still exist because of anxiety about the future, poor living conditions, and unemployment (MSF, 2020a; Ullah et al., 2023). Since 2017, the overall health status of Rohingya refugees is improving but remains fragile. The Rohingyas receive health services according to the policies and approaches set by the local authorities and international agencies. The marginalised Rohingya people do not have any voice in conventional health services; rather, they are the passive users.

Six years after the 2017 Rohingya exodus, funding has become a major barrier (UN News, 2023). The Bangladeshi Government has been hosting the Rohingyas for decades with the help of the international community (Macdonald et al., 2023). The international donors have reportedly focused their attention to the ongoing Ukraine conflict and Afghanistan crisis (Sajjad, 2022). Because of this changed focus, the funding for Rohingyas has considerably dwindled (Hossan, 2022). International aid organisations regularly call for sustained funding and support for Rohingya refugees emphasising the need to ensure that the Rohingya situation does not become a forgotten crisis (UNHCR, 2022d). However, the funding for Rohingyas is decreasing every year. From March 1, 2023, the World Food Programme (WFP) reduced the value of a General Food Assistance voucher from US$12 to US$10 per

Rohingya per month due to a US$125 million funding shortfall (WFP, 2023a). Then again in September 2023, the WFP further cut the food ration and now each Rohingya gets $8 per month or 27 cents per day (Pirovolakis, 2023). The UN experts fear that the WFP food cut will result in higher malnutrition among the Rohingyas who were already living in food insecurity (UN, 2023).

Chapter 4: Research methodology

4.1 Culture-Centred Methodological Approach

The Culture-Centred Approach (CCA) to health communication is founded on the basis of centralising cultural voices in the articulation of health problems and solutions (Airhihenbuwa, 1995; Dutta-Bergman, 2004a, 2004b, 2005). In CCA, theory building is developed from below with the engagement of "margins of the margins" who have traditionally been silenced by the dominant theories and models of health communication (Dutta, 2007). The mainstream health communication theory reflects the capitalist and colonialist role of communication as an instrument for disseminating techniques and/or technologies. But the CCA inverts the concept of communication inequalities by exploring the distribution of opportunities for voices of the marginalised communities (Dutta et al., 2019). The CCA is both driven toward theory-building from within the community and driven toward foregrounding solutions that emerge from within communities (Dutta, 2015).

Dutta (2018) has mentioned that the CCA is a framework for addressing health inequalities by building communicative infrastructures for listening to the voices of subaltern/ marginalised communities, such as the Rohingya refugee communities that are hitherto erased from dominant discursive spaces. CCA turns the intersectional lens of culture, structure, and agency, upon communities such as that of the Rohingya refugee communities advocating for spaces of dialogic engagement with subaltern narratives and agency, seeing communicative marginalisation as the seed of structural marginalisation (Dutta, 2008, 2011; Dutta-Bergman, 2004a, 2004b). CCA envisions culture as a dialectic and contextual process

where understandings of health are socially negotiated within defined communities like the Rohingyas (Basu & Dutta, 2008) creating spaces of shared meanings, values, and interactions which are components of culture (Dutta, 2008).

In CCA, dialogue is enacted using open-ended in-depth interviews that build the communicative infrastructure for knowledge generation (Dutta, 2018). The goals of in-depth interviews at the community level are to understand the communication needs of the local communities, explore their communication capacity requirements for the development of community solutions, and co-create dialogues that generate theories of health from the bottom or "margins of the margins" (Dutta-Bergman, 2004a, 2004b; Basnyat, 2014; Yehya & Dutta, 2010). In-depth interviews produce "profound narratives [which] form a living discourse . . . [and] descriptive stories [which] disclose life beyond a time and place" (Hopson, 2011, p. 4). In CCA, this semi-structured open-ended interview method typically consists of "a dialogue between researcher and participant, guided by a flexible interview protocol and supplemented by follow-up questions, probes and comments" (DeJonckheere & Vaughn, 2019, p.1).

Besides semi-structured in-depth interviews, CCA methodology also utilises participant observation, reflexive journaling and photovoice (Borron, 2013). Advisory group meetings are also the part of Culture-Centred process, through which CCA continues to work for the community (Dutta, 2018). In the Culture-Centred Approach, no research can succeed without researchers showing solidarity and placing their body on the line (Dutta et al., 2019). However, in the Cox's Bazar Rohingya refugee camps settings, it is not feasible to organise advisory group meetings and photovoice workshops as the entry into the camps is highly restricted. A researcher is allowed to talk with the Rohingya refugees only with permission

from the appropriate Bangladeshi authorities. For this study, then, the semi-structured in-depth interviews of the participants have been utilised as the principal method of data collection. Other methods, such as focus group discussions (FGD), participant observation, field notes taking, memoing, reflexivity and solidarity have been employed in addition to the interview method. A total of 41 in-depth interviews and five FGD were conducted at different refugee camps during the field work.

4.1.1 In-depth interviews

In CCA, the formal interview technique or the question-answer procedure is not followed; rather, the interviews are considered as conversations that occur symmetrically between the researcher and participants on a topic of mutual interest. The semi-structured open-ended in-depth interviews usually start with open and broad questions that allow participants to narrate their lived experiences or meaning of a phenomenon without any restriction. Kallio et al. (2016) observed that the most common type of interviews used in qualitative research especially in the healthcare context was semi-structured in-depth interviews. In the current research, I also utilise the semi-structured in-depth interview method based on CCA.

DeJonckheere and Vaughn (2019) have mentioned that semi-structured in-depth interviews have the following advantages:

1) Loose and flexible structure
2) Iterative
3) Groups or individual participants
4) Scheduled in advance
5) Gather information from key informants who can inform the topic

6) Insight into participant perspective
7) Deep exploration of participants' thoughts and experiences
8) Often the sole data source for a qualitative study.

Lindlof and Taylor (2002) observed that qualitative in-depth interviews were "a storytelling zone par excellence" (p. 174) empowering researchers to explore how participants describe their identity, culture, and life experiences. The semi-structured open-ended in-depth interviews with the Rohingya community members offer insights into the constructions and challenges of communication, everyday meanings of health, challenges to health, and the solutions that are envisioned in the context of health challenges experienced by community members (Dutta, 2018). The goals of the Rohingya refugee interviews are to understand the material and communicative needs of the refugees residing in the camps, the everyday contexts of health and living, and the community thoughts for the design and delivery of solutions (Dutta, 2019). The interview questions range from seeking Rohingya participants' meanings of health, their lived experiences of staying in a refugee setting, and their involvement in the definition of health problems and solutions.

4.1.2 Focus Group Discussion

A focus group discussion involves people from similar backgrounds or experiences gathering to discuss a specific topic of interest. The FGD is generally guided by a facilitator, also called a moderator, who facilitates the discussion and promotes the communication among the participants. FGDs are semi-structured group conversations led by a moderator (Krueger & Casey, 2009). FGD is a form of group interview where the researcher and a small group of participants interact on sets of targeted questions designed to elicit collective viewpoints on

issues specific to the research interest (Ryan et al., 2013). The focus group discussion is a suitable method of data collection, as here the participants can interact and respond to each other, which inspires them to reveal thoughts and ideas they would not have raised had they just completed a questionnaire (Lune & Berg, 2017).

In the Rohingya refugee camps, I conducted a total of five FGDs during the fieldwork ranging in size from two to ten participants. These FDGs were closely linked with the in-depth interviews. In fact, where I had the opportunity to interview several participants at the same or close-by locations, I also invited them to participate in a focus group discussion. In my first FGD, three Rohingya females participated in the discussion. Another day, I visited a house where four sisters lived together. I found three of them present during my visit and talked with them together.

I also visited the Hindu para (a specialised camp where only Hindu Rohingyas live) and ten Hindu Rohingyas took part in the focus group discussion (Figure 11: FGD with Hindu Rohingyas). This Hindu Para FGD was the most fruitful one out of the five as the ten people took part in a vibrant discussion.

4.1.3 Participant observation

In qualitative research, participant observation is employed to understand the diverse perspectives of the participants in a specific setting, such as the Rohingya refugee camps. Bernard (2017) has claimed that participant observation gives the researcher a unique view as it provides an emic [a study that showcases one culture with no (or only a secondary) cross-cultural focus] understanding of the people of the study. Rendering first-hand information,

participant observation technique considers the behavioural patterns and events of the study group that the participants may not be willing to share (Jennings, 2010). Participant observation was essential in understanding various aspects of Rohingya refugee camp life from a healthcare perspective, which includes health status of the participants, economic transactions, relationships with neighbours, relationships among the Rohingyas, outside influences, etc.

I utilised participant observation at four different stages: firstly, during visits to the Rohingya refugee camps; secondly, while conducting semi-structured in-depth interviews; thirdly, at the time of focus group discussions; finally, during my more than three years of interactions with the Rohingya communities in New Zealand. During my fieldwork and pilot study at the Rohingya refugee camps, I was a participant observer and collected data through observation and note-taking besides conducting interviews and FGD. In 2022, I stayed 22 days in the Cox's Bazar Rohingya refugee camp area for my PhD fieldwork. Earlier in 2020, I stayed three days in Cox's Bazar town and visited the refugee camps daily for my PhD pilot study. A few years ago, I also paid a one-day visit to the Rohingya camps as a journalist with the entourage of the then United Nations Secretary General. Besides these one-off visits, my interactions for more than three years with the Rohingya refugees living in New Zealand gave me a detailed knowledge of the Rohingya refugee lives through participant observations. Additionally, I worked on the Rohingya refugee crisis from August 2017 to February 2020 while I was a news producer of the state-owned Bangladesh Television and produced over 100 visual news reports on the crisis. During this time, I also produced a 12-minute video documentary on the Rohingya crisis. From March 2020 till writing this thesis, I have engaged myself with the Rohingya refugees living in New Zealand in different capacity (i.e., as a research interviewer and a social worker). I have also presented Rohingya-related papers at

international conferences. A brief description of my participant observation role with the Rohingya refugees is outlined below in Table 3.

Table 3: Rohingya participant observation timeline

Date	Event	Location	My position
August 2017-February 2020	Producing more than 100 visual news reports on Rohingya crisis https://www.youtube.com/watch?v=L9ApdeyF1Ag&list=PLydyw2P14fp3aMxfa2A8pParGa3RZzH8M	Newsroom Bangladesh Television Bangladesh	News Producer
2nd July 2018	Live reporting from Rohingya refugee camps (Cox's Bazar) for 2 pm bulletin of Bangladesh Television (BTV) https://youtu.be/jM1jlQxJWHo	Cox's Bazar Refugee camp Bangladesh	Journalist to cover UN Secretary General visit
2nd July 2018	News report on UN Secretary General visit to Rohingya refugee camps (Cox's Bazar) for 8 pm Bulletin of BTV https://youtu.be/28-CyHRiaQs	Cox's Bazar Refugee camp Bangladesh	Journalist to cover UN Secretary General visit
20 July 2018	Documentary titled "UN Secretary General in Bangladesh – Future of Rohingyas" https://youtu.be/0I116odTLaA	Newsroom Bangladesh Television Bangladesh	News Producer
February 2020	Pilot study on Rohingya refugees living in Cox's Bazar refugee camps	Cox's Bazar Refugee camp Bangladesh	PhD Researcher
February 2020	News report on Learning Centres at the Rohingya camps (based on pilot study) https://youtu.be/EMkvjsHFm68	Newsroom Bangladesh Television	News Producer

		Bangladesh	
March 2020-December 2021	Attending various activities of the Rohingya refugees resettled in New Zealand while dealing the Rohingyas for various projects of CARE (Centre for Culture-Centred Approach to Research and Evaluation)	Palmerston North New Zealand	Research Assistant CARE
May 2021	ICA Conference presentation on Rohingya crisis. Conference topic was "Negotiations of Health Among Rohingya Refugees in Cox's Bazar, Bangladesh: A Culture-Centred Approach to Health and Care" https://youtu.be/FmlqyP9dcLc	CARE Massey University Palmerston North, NZ	Research Assistant CARE
December 2021-January 2022	Fieldwork at Rohingya refugee camps of Cox's Bazar, Bangladesh	Cox's Bazar Bangladesh	PhD Researcher
August 2022-till date	Attending various activities of the Rohingya refugees resettled in New Zealand while dealing the Rohingyas for various projects of CARE	Palmerston North New Zealand	Research Assistant CARE
28 Nov-02 Dec 2022	Panel presenter at the CARE 10th Anniversary Conference 2022. The topic was "Refugee organising at the margins." https://youtu.be/IB3y3Z4wBcw	CARE Massey University, NZ	Research Assistant CARE
27 – 28 May 2023	Presenter at the ICA CARE Pacific Hub Workshop organised by CARE, Massey University at Palmerston North, New Zealand. The topic is "Rohingya refugee negotiations of COVID-19 at the '"margins of the margins."' The link of the panel discussion (Hybrid - Online & In-person): https://youtu.be/_qd-td7H2JA	CARE Massey University, NZ	Research Assistant CARE

Thus, I have been directly or indirectly observing the Rohingya communities as a participant observer since August 2017. However, my first direct or in-person Rohingya observation

occurred on 2 July 2018 during my first visit to the Rohingya refugee camps in Cox's Bazar. Then I did the next in-person Rohingya observation in February 2020 during my PhD pilot study at the Rohingya camps and in December 2021-January 2022 during my PhD fieldwork. During this fieldwork, I stayed for 22 days in the Rohingya refugee camp area and my accommodation was located within the walking distance of the refugee camps. This very close location helped me to observe for an extended period the overall activities of the Rohingya refugees living there. I was engaged in participant observation during the interview processes, i.e., travelling/walking to various camps, while negotiating the interviews, and while conducting the interviews. Most of the interviews had been conducted at the shelters/houses of the Rohingya interviewees with the help of a Rohingya interpreter. I made mental observation notes when I walked around the refugee camp area to find potential participants or returned after the day's interviews. I also did so during the actual interviews and my stay at the accommodation.

I have continued my participant observation of the Rohingya community members who live in New Zealand. Since March 2020, I have observed the Rohingya participants at their homes, community halls, shopping centres and during special tours. Besides, I have also had the added opportunity of observing them during Islamic religious festivals including Eid-ul-Fitre and Eid-ul-Azha and during daily prayer times at the Palmerston North Islamic Centre. I often get engaged in informal discussions with the Rohingya refugees and learn about their lives and experiences in New Zealand.

4.1.4 Field notes

Field notes are taken by a researcher to remember and record the behaviours, activities, events, and other features of an observation object during the fieldwork of a research. Field

notes allow the researcher to observe the scene, take down happenings as events occur, and note how participants respond to the researcher's presence and interactions with them. Anderson (1987) explained that field notes are "the product of observation and participation at the research site and considered reflection in the office…. They are written so the analyst can re-enter the scene of the action and of the research at a later date" (p. 341). Kawulich (2005) stated, that field notes serve as a record of activities or ceremonies observed and informal discussions held during the fieldwork of a researcher. Maanen (1988) stated, field notes are "gnomic, shorthand constructions of events, observations, and conversations that took place in the field" (p. 123). There is no set definition of what field notes should or should not contain: as Sanjek (1990) explained field notes are "a body of description, acquired and recorded in a chronological sequence" (p. 99).

During my PhD fieldwork, I carried a notepad to write the field notes. I mainly wrote my notes after the interviews were finished or when the participants asked to stop the audio recorder. When I was unable to write something down in detail in my notepad, I made scratch notes (short-hand notes) and then completed the notes when I returned my accommodation at the end of the day of interviews at the refugee camp. My field notes took various forms as I wrote them on the notepad – from words to full sentences written in Bangla, English or some diagrams to help me understand and remember the scene of that day. I did not take detailed field notes of my daily events in the Rohingya refugee camps as the interviews/conversations were audio recorded. Rather, I took field notes on the events that may be missing in the conversations and my observations that seemed important to note down.

4.1.5 Memoing

Memoing is the record of the researcher's thinking during the fieldwork. Memoing serves as an important element of social science research as it assists "the researcher in making conceptual leaps from raw data to those abstractions that explain research phenomena in the context in which it is examined" (Birks et al., 2008, p. 68). There are some differences between field notes and memos. Field notes are written records of observational data produced by fieldwork (Hammersley & Atkinson, 2002). Memos, on the other hand, are records of the researcher's developing ideas and thinking (Glaser, 1998). Memos are a researcher's views rather than a description of a social context and "by theorizing from the data, memos transform field-note descriptions into theoretical accounts" (Montgomery & Bailey, 2007, p. 68).

Memoing performs a significant role in research as the memos are fodder for the larger data that the researcher can compare and develop once s/he leaves the research field. During the processes of data collection, coding and, finally, theory generation, memos serve as practical analytic tools. A memo has no approved structure; it may be long or short and its format may vary from person to person (Birks et al., 2008). The best approach to memo writing is to "do what works for you" (Charmaz, 2006, p. 80). Charmaz (2000, p. 518) also observed that memo writing helps researchers to:

- grapple with ideas about the data
- set an analytic course to refine categories
- define the relationships among various categories, and
- gain a sense of confidence and competence in their ability to analyse data.

In this project, I have also employed the memoing technique based on the Culture-Centred Approach to document my initial reactions, thoughts, and ideas throughout the fieldwork at the Rohingya refugee camps. For example, using the memoing procedure helped me to see I would not get a fruitful result by accepting help from the CIC to select participants for in-depth interviews. Consequently, I declined to take help from CIC and made the decision to select the Rohingya participants only by discussing with the Community researcher (Rohingya interpreter).

4.1.6 Reflexivity

Reflexivity is a type of critical reflection of the positionality of a researcher and how he/she has taken this stance into account in the research process. It is the process of continual reflection throughout the research process by a researcher and the main component of reflexivity is the idea of self-awareness. Reflexivity goes beyond the "reflection" in that sense, in that it explores the researcher's relationship with other things (i.e., research participants and site) (Roulston, 2010). To define reflexivity, Roulston (2010) said: "the researcher's ability to be able to self-consciously refer to him or herself in relation to the production of knowledge about research topics" (p. 116). Olmos-Vega and co-authors (2022) expand this definition in more specific terms: "Reflexivity is a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes" (Olmos-Vega et al., 2022, p. 242). Reflexivity involves a researcher's positionality, awareness, assessment, and reassessment of the total research process (Patnaik, 2013). Reflexivity implies that the researchers may be biased by their preconceptions, beliefs, values, interests, and their social locations (Hammersley & Atkinson, 1983). However, for

good research work, researchers should recognise and distance themselves from prior assumptions and beliefs that could affect findings and interpretations.

In the Culture-Centred Approach, dialogic engagement with the cultural participants is a co-construction process, where the researcher needs to demonstrate openness, trust, and reflexivity (Dutta, 2011). Reflexivity is considered as a key tenet of CCA that locates the researcher into the cultural space owning up to his or her position of power (Dutta, 2008). "By locating expertise within the culture instead of external actors, a culture-centred approach requires a reflexive process of inquiry on the part of the researcher" (Dutta et al., 2012, p. 11). Dutta (2007) observed that a focus on reflexivity would allow the researcher to take the step back as an expert in understanding the lived experiences of the participants, rather to work as a co-participant who was involved with facilitating the stories of those marginalised experiences. In CCA, reflexivity works as a methodological tool that allows researchers to ponder upon their positions and influences in the co-creation of talk (Basu & Dutta, 2008, Dutta, 2007, 2008).

The current study of the Rohingya health issues is a subaltern study. In any subaltern study, the researchers need to exercise their reflexivity by acknowledging their privileged positions in the dominant structures and should be careful that their positionality may not be the cause of further erasure of the subaltern community (Dutta et al., 2012). In this study I used semi-structured open-ended in-depth interviews and a cautious focus on reflexivity allowed me to explore the relationship between myself and the Rohingya participants. Throughout my PhD fieldwork, I constantly worked on reflexivity and thought about the power relationships between me and the Rohingya participants. I also considered my privileges as someone who could easily move within and outside of the camp area while my interviewees (Rohingya

participants) were confined within the camps. Again, I was always reflexive to think about my positionality being a member of mainstream society of Bangladesh and always careful about my attitudes towards them. Fostering a reflexive attitude throughout this research project, I could notice my limitations as a researcher, along with the advantages I was afforded due to my prior work experiences with the Rohingya refugees. This started with designing an interview process to potentially facilitate more productive engagements between the interview participants (Rohingyas) and myself by tweaking both the language of the interactions and questions and the design of the interview process.

4.1.7 Solidarity

The basic meaning of solidarity is togetherness, and it stands for people helping and supporting each other (Otto, 2022). Solidarity has been defined as a recognition of common interests or goal (Engels, 1975); a sense of belonging to a group or culture (Rorty, 1989); a sense of non-calculating cooperation based on identification with a common cause (Ter Meulen, 2016); shared social ideals (Brunkhorst, 2005); a shared form of collective life (Habermas, 1991); and showing empathy (Bartky, 2002). Solidarity encourages the gathering of knowledge, which is sought in any research (Łuków, 2022; Pratt et al., 2020). Through solidarity research participants find themselves working together with researchers as a team, and, helping one another to achieve the goal of a study (Ralefala et al., 2020). The principle of solidarity is that the team members look out for each other as Metz (2017) indicated, “once a researcher and a participant have begun to think of themselves as a ‘we’ engaged in the joint project of a study, they have formed a tie that imposes special obligations to care for one another’s quality of life that can go beyond those listed in a participant agreement form” (p. 117).

Building solidarity between researcher and participants is a central aim of the Culture-Centred Approach (Basu & Dutta, 2011). CCA believes that building solidarity with the marginalised community is as much an essential component of doing fieldwork as any other tool for gathering data (Dutta, 2008). However, acknowledging the researcher's power and position is the first step toward beginning a journey of solidarity between the researcher and the cultural members of a community (Dutta et al., 2012). Utilising CCA, the researcher's role should be as a solidarity activist that allows him or her to understand the meaning making and communicative processes in the marginalised spaces of Rohingya refugee people. Listening is central to the Culture-Centred Approach as a means of working "in solidarity with the margins to co-construct theory rooted in the ontologies, epistemologies, and values of the margins" (Dutta, 2014, p. 68).

In building solidarity with the Rohingya refugee participants, I utilised my previous working experience with them. Moreover, the cultural and religious similarity between me and the Rohingya participants also helped to build a good relationship with them. I always showed my solidarity with the prolonged struggles of the Rohingya refugees. Throughout my research work that started with the Rohingya refugee crisis in August 2017, I have showed my solidarity with the hardship experienced by the Rohingya people. Since I started interacting with the Rohingyas living in Bangladesh, I have never stopped my engagement and solidarity with the world's most distressed people as I continue to deal with the Rohingyas living in New Zealand till today.

4.1.8 Placing the body on the line

The Culture-Centred Approach (CCA) believes in academic-community partnerships; this relationship becomes stronger when the researcher places her/his/their body on the line of the struggles of the community. Dutta et al. (2019) observed that CCA works "through the concept of 'placing the body on the line' to depict the ways in which the body of the academic, turned vulnerable and weaponised in active resistance to neocolonial/capitalist structures, disrupts the hegemonic logics of power and control that shape health within these structures" (p.1). CCA also believes that the presence of the researcher's body should be placed in solidarity with marginalised, such as Rohingya refugees' struggles for voice that disrupts the state's neoliberal governmentality (Dutta, et al. 2019). Placing my body on the line of the struggles of the "margins of the margins" Rohingya refugee community living in the Bangladeshi camps helped me to find out their voice infrastructures relating to health and wellbeing.

For example, by risking my life during the Covid-19 pandemic time, I visited the Rohingya refugee camps to collect their lived experiences and erased voices. Again, in my permission letter of RRRC, it was mentioned that whenever I entered the camps, I had to inform CIC, that I intentionally did not follow which may risk my data collection procedure. During daily visits to the camps, I overlooked the guidelines of visiting CIC as CIC provided me with a volunteer that created a barrier to find out the real-life stories of the Rohingyas. I did this as I observed, Rohingya refugees were not open enough in presence of a CIC representative, during conducting the interviews. After conducting my PhD fieldwork, I was stuck up in Bangladesh as the New Zealand border was closed because of Covid-19 pandemic. Even New Zealand immigration asked me to do a TB (Tuberculosis) test to provide me the visa to re-enter when the New Zealand border was open after two years of Covid closure. So, I

placed my body on the line, and I risked my life to collect the data from the Rohingya campground of Bangladesh.

CCA believes in listening as the main tool to observing the participants' lived experiences and it works through the concept of reflexivity and solidarity by placing the researcher's "body on the line" as a starting point to depict the ways of everyday meanings of life of the participants (Dutta et al., 2019). Members of refugee communities sometimes see researchers/ academics as "tourists" who sightsee in the camps but give little in return for community development. (Mahtani, 2018). However, by placing my body on the line, I could achieve an understanding of the grounded realities of the lives of the Rohingya refugees at the camps. What was particularly valuable in the process of showing my solidarity was always reminding myself of the importance of 'making a difference' through this research, by "placing the body on the line."

From 2017 to today, I continuously work for the welfare of the Rohingya refugee community. I have placed my body on the struggles of Rohingya refugees by writing news stories, Op-Eds, public pieces to create awareness and to solve the long standing Rohingya refugee crisis. Though the Bangladesh government does not refer to the Rohingyas as 'refugees' rather label them as 'FDMN,' however in my writings I always use the term 'refugees' to describe Rohingyas. I do believe if the marginalised Rohingya people may be termed as 'refugees' then they may get some more opportunities in Bangladesh and other countries where they take shelter.

4.2 Research Design

For my research project, the qualitative research method of a Culture-Centred Approach (CCA) was used to explore and understand the construction of health among the Rohingya refugees living in various camps of Bangladesh. The primary goal of this study was to find out the construction of health among the Rohingya refugees living in Bangladesh, since the refugees have a documented history of health issues after resettlement in various camps of Bangladesh. To address the health meanings of Rohingya refugees in the dominant discourse, a case study of the healthcare issues faced by these refugees was conducted utilising CCA tenets of structure, culture and agency. Hence, this project locates itself within a qualitative research strategy using semi-structured face-to-face in-depth interviews for data collection (Basu & Dutta, 2009; Corbin & Strauss, 2008; Lindlof & Taylor, 2002).

These semi-structured, open-ended, in-depth interviews of the Rohingya refugees living in various camps of Bangladesh were aimed at facilitating the emergence of concepts of health from the ground up through engagement with the participants. The in-depth interviews were used to explore in detail the participants' personalised lived experiences, perceptions and accounts relevant to the study and obtain an elaborate understanding of the concept of health for further investigation and descriptive analysis (Kaufman, 1992; MacDonald, 2012; Patton, 1987). The author used a semi-structured interview schedule for the Rohingya refugees at various refugee camps in Cox's Bazar, which allowed for unplanned additional follow-up questions throughout the interview process (Ross et al., 2014).

In the in-depth interview process in CCA, participants lead the dialogue, and the role of the researcher is to listen to their narratives and then place those stories from the margins in the dominant communication narratives. In the current research, this process has been followed.

During the in-depth interviews, the researcher "gently guides a conversational partner in an extended discussion" (Rubin & Rubin, 2005, p. 4). The questions were kept open-ended, grounded in explorations of the meanings of health and wellbeing in the lives of Rohingya communities of the camps. Examples of these questions that broadly engaged in explaining the meaning-making process in my research project include a) What does health mean to you? b) What difficulties do you experience in living in the camps? c) How do you negotiate these challenges to health? d) What solutions do you foresee to solve health related issues and challenges? These open-ended questions were aimed at engendering a broad and considered response and creating a conversational environment so as to open up the way for an extended discussion with the Rohingya participants. In this way, I tried to dilute the unspoken power of the "interviewer" vis-a-vis the Rohingya participants.

For interviewing the Rohingya refugees, I spent 22 days in December 2021-January 2022 in Cox's Bazar area of Bangladesh. For the first three days, I stayed in Cox's Bazar town to obtain permission from the Bangladeshi authorities for my entry into the camps. For the remaining 19 days, I stayed in the Ukhiya upazila (sub-district) of Cox's Bazar district and conducted interviews and observed the lives of the Rohingya refugees. As mentioned earlier, about 80% of the Rohingya refugees who are in Bangladesh reside in Ukhiya upazila. My research is also an ethnographic study of the Rohingya refugees living at various camps of Cox's Bazar. In ethnography, a researcher observes the behaviours and interactions of individuals using observations, interviews, and documentary data to produce detailed and comprehensive accounts of different social phenomena (Reeves et al., 2013). I accomplished my study through ethnographic fieldwork using semi-structured interviews based on CCA.

Research work in a refugee camp area with vulnerable populations, such as displaced Rohingya people, documented/undocumented refugees, and people who have experienced decades-long persecutions and violence, involves various challenges that need to be negotiated by the researcher during the fieldwork (Farzana, 2018; Rahman, 2022b). To conduct research in any refugee camp, the researcher should keep in mind that the research work must not create any situation that puts the participants in further risk. Hugman et al. (2011) argue that research with vulnerable populations like refugees may even fail if the refugees are left at further risk by the research process. In addition, Covid-19 both threatened and limited research work in the refugee camp setting. Thus, in the research design of the current project, I had to consider these issues before starting my fieldwork at the Rohingya refugee camps of Cox's Bazar, Bangladesh.

4.2.1 Preliminary works (pilot study) before PhD fieldwork

Before starting my main study, I conducted a pilot project on the Rohingya refugees and stayed three days in Cox's Bazar in February 2020. During this time, I stayed in Cox's Bazar town and visited the Rohingya refugee camps daily to conduct 12 in-depth interviews of the Rohingya refugees. In Social Science, a pilot study can refer to feasibility studies which are "small scale version[s], or trial run[s], done in preparation for the major study" (Polit et al., 2001, p. 467). A pilot study is the first step of the entire research protocol and is often a smaller-sized study that helps to develop proper samples and sampling techniques (Hassan et al. 2006; In, 2017). In consultation with my PhD Supervisor Prof. Mohan Dutta, I carried out the pilot study. This study helped me to find out about the Rohingya health topic and figure out the best way to study it at the refugee camps of Cox's Bazar, Bangladesh. Through this pilot study, I came to know that without getting proper approval from the Bangladeshi

authorities, no researcher is allowed to enter the Rohingya refugee camps of Bangladesh. I also got an overall picture of the Rohingya refugee camps of Bangladesh through this pilot study. Again, through this pilot study I realised that it would not be feasible during my PhD fieldwork to stay in the town at Cox's Bazar and visit the Rohingya refugee camps every day to collect data.

4.3 Gaining entry for PhD fieldwork

As mentioned above, during my pilot study, I came to know that researchers need to seek and obtain formal approval from the Bangladeshi refugee authorities to enter the Rohingya refugee camps of Cox's Bazar. I also came to know that the relevant authority is the Refugee Relief and Repatriation Commissioner (RRRC) office, which is situated in Cox's Bazar district headquarters (Cox's Bazar town). So, before leaving New Zealand for my fieldwork, I contacted my former BTV colleague at Cox's Bazar to find out about the formal process of approval from the RRRC office. I also requested him to give me an idea about my potential accommodation either in Cox's Bazar town or any other suitable place near the refugee camps as my plan was to stay around one month near the Rohingya refugee camp area. My colleague informed me that staying in Cox's Bazar town would be expensive, because besides the high price of accommodation in this tourist town I would have to pay for a hired vehicle for my daily commute to and from the refugee camp. He advised me that I could stay at the BTV rest house (i.e., a Government of Bangladesh property) in Ukhiya upazila, which was very close to the refugee camps. Once I reached Dhaka, the capital of Bangladesh, from New Zealand, I contacted BTV officials in Dhaka to obtain permission to stay at the BTV rest house in Ukhiya. As the BTV was my previous workplace, it was easy for me to obtain this permission to stay at BTV rest house for my entire PhD fieldwork period. From my

former colleagues at the BTV's Dhaka Office, I also managed to find out the contact phone number of the person responsible for the BTV rest house in Ukhiya to organise my arrival date and other matters pertinent to my stay at the rest house.

4.3.1 Arrival at Cox's Bazar town from Dhaka

After obtaining permission from the BTV authorities, I travelled from Dhaka to Cox's Bazar by bus which was cost-effective although time-consuming. Cox's Bazar is the prime tourist spot of Bangladesh with its long natural beach along the Bay of Bengal. It attracts local and foreign tourists all through the year (Hà, 2023). This makes this town a busy yet expensive place. Besides, following the recent Rohingya exodus in 2017, this small seaside town has now become a hub of activity for local and foreign humanitarian aid organisations. The staff of these organisations stay in Cox's Bazar town and work at the Rohingya refugee camps. As mentioned earlier, the 33 Rohingya refugee camps, situated at Ukhiya and Teknaf upazilas, are about a two-and-a-half-hour journey by road from Cox's Bazar town. I decided to visit the Rohingya refugee camps in the middle of December 2021 as the Covid scenario of Bangladesh was good at the time with less than 2% infection rate. After arrival, I visited the RRRC office and submitted my application for permission to enter into the refugee camps as a researcher. It took two days to get the permission letter from the RRRC office. Then, I started towards the Rohingya refugee camps from Cox's Bazar town to start my fieldwork.

4.3.2 Arrival at Ukhiya upazila from Cox's Bazar

After reaching my destination, I had a discussion with the BTV rest house in-charge about finding a suitable Rohingya interpreter. The Rohingya refugees do not know English but some of them know Bengali (Bangla), my mother tongue. So, I tried to find a Rohingya interpreter who knows both Bengali and Rohingya language. I explained to the BTV person that, during the in-depth interviews, I would generally ask questions in Bengali and the Rohingya interpreter would translate it into the Rohingya language. In turn, the Rohingya participants could answer in their own Rohingya language, and their answers would again be translated into Bengali by the interpreter. The whole process would be audio-recorded. I briefed my interview process to the BTV rest house in-charge so that he could find a Rohingya interpreter for me, with a good knowledge of both the Rohingya and Bengali languages. An interpreter was indeed found, and on the fourth day of my fieldwork, I could start my formal visit to the Rohingya refugee camps of Ukhiya. The interview process went on as described above, but later I found that some of the Rohingya male participants also answered in Bengali, while the female Rohingyas always took part in the discussion using the Rohingya language.

Link Two

A part of chapter 4 (4.3.3) titled, “Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh” has been published in the Indiana Journal of Humanities and Social Sciences.

After completing my PhD fieldwork in the Rohingya refugee camps of Cox’s Bazar from December 2021-January 2022, I wrote this article on the challenges I faced in conducting the fieldwork in the restricted refugee camps (researchers are not allowed without permission) of Cox’s Bazar. It describes practical experience and challenges I faced in the field while collecting data utlising three triads of the Culture-Centred Approach: culture, structure and agency. In this article, I mentioned that placing the researcher’s “body on the line” was a starting point in CCA. It also established solidarity with the research participants to depict the ways of everyday meanings of their lives. The article also outlines the required overall strategies I adopted during my fieldwork at the refugee camps of Bangladesh. Both of my supervisors, Professor Mohan Dutta and Dr. Akhteruz Zaman, provided feedback on the draft of the article.

I submitted the article on 28 July 2022, and the journal published it on 23 September 2022 following peer reviews.

4.3.3 Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh:

(A published article)

Rahman, M. M. (2022). Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh. ***Indiana Journal of Humanities and Social Sciences, 3*****(9), 22-31. https://doi.org/10.5281/zenodo.7123481.**

Abstract

Rohingya refugees or Forcibly Displaced Myanmar Nationals (FDMNs) have been living in Bangladesh for four decades. Before the latest 2017 exodus, only two registered camps and some unregistered spots lying with the registered camps were present in the Cox's Bazar area of Bangladesh to host the Rohingya people. However, currently 33 makeshift camps are hosting around one million Rohingya people from Myanmar. The government of Bangladesh prohibits visitors' (including researchers) access to those camps without prior official permission. The bureaucratic hurdles for securing permission from the respective office to get into the camps are lengthy, difficult, time consuming, and involve visiting the respective office which is far away from the refugee camp area. Besides, research in any humanitarian settings, such as the Rohingya camps containing vulnerable communities require some special ethical considerations. This paper draws on fieldwork experiences among registered and unregistered makeshift camps of Cox's Bazar, Bangladesh. It sheds light on practical experience and challenges in the field and required strategies by a researcher to do a productive fieldwork overcoming all the challenges. It also suggests various negotiations at multi-level complexities of humanitarian settings to overcome challenges that interrupt research plans at different stages of research, which require timely and contextual adaptations.

Introduction

Research work in any emergency setting like a refugee camp is critical to find out the needs of refugees living in that camp and for the development of existing policies and programs taken for the refugees (Beogo et al. 2018). Research at humanitarian settings helps humanitarian bodies and donor agencies to take appropriate decisions on how to efficiently deliver the most effective interventions under acute resource and time constraints (Blanchet et al. 2018). Effective collaboration between humanitarian actors (like donor agencies, UN bodies, national and international non-government organisations- NGOs) and researchers can ensure that the resources allocated for the refugees are noteworthy, as well as properly distributed and utilized, as per need, and not wasted (Turner et al., 2011). However, research work in a refugee camp area with vulnerable populations, including displaced people, documented/undocumented refugees, and people who have experienced long persecutions and violence, involves various challenges that need to be negotiated by the researcher during the fieldwork (Farzana, 2018). Besides these regular challenges, the recent Covid-19 pandemic situation also placed a serious threat to research work and often limits the works of researchers in the refugee camp settings.

Reliable, and relevant information is very much needed to handle complex humanitarian crisis like Rohingya refugee crisis. Based on the accurate information, appropriate need-based service packages and interventions that address refugees' requirements can be designed and resources mobilized accordingly (Checchi et al., 2017). However, research-generated information becomes challenging if evidence fails to apprehend the wider socio-political, socio-economical, and socio-cultural dimensions of the problem, along with the actual needs of the vulnerable population living at the humanitarian settings (Bradt, 2009; Darcy et al., 2013). Overcoming the challenges created on the ground, a researcher always tries to find out

the evidence-based data of the community living in the humanitarian settings. This section discusses the challenges and proposed strategies of ethnographic study by considering the researcher's field experiences of the documented and undocumented Rohingya refugees living in Cox's Bazar, the South-eastern district of Bangladesh. This study may help other researchers to understand the potential challenges and identify appropriate strategies for conducting research in humanitarian settings similar to the Rohingya refugee camps of Bangladesh.

Rohingya camps of Bangladesh

Cox's Bazar, a border district of Bangladesh, close to the Rakhine state of Myanmar, is now hosting more than 1.3 million Rohingya refugees who fled persecutions and violence in Myanmar. The first forced migration of the Rohingya community towards Bangladesh occurred in 1977-78. This exodus was followed again in 1991-92, 2012, 2016, and 2017 to the present days (Ahmed, 2009; HRW, 2012; Acaps, 2017). In 1977-78, more than 250,000 Rohingyas landed in Bangladesh facing persecutions, torture, rape, and jail by the then Burmese Army, in the name of registering Burmese citizens and screening out foreigners (i.e., Rohingyas) (Rahman & Mohajan, 2019; Habib, 2021). At that time, 12 refugee camps were established in the Cox's Bazar area and one camp in Bandarban area of Chittagong Hill Tracts (HRW, 2000). However, an agreement between Bangladesh and Burma in 1979 saw most of the Rohingyas returned to their homeland and all camps of Bangladesh were closed (Akhter & Kusakabe, 2014). Again in 1991-92, more than 270,000 Rohingyas fled to Bangladesh facing forced labor, rape, and religious persecution at the hands of the NaSaKa and other Myanmar state agencies, as many as 20 camps were established at the Cox's Bazar area to provide shelter to the Rohingyas (Yesmin, 2016). Following an agreement between Bangladesh and Myanmar in 1992, most of the Rohingyas were repatriated between 1992 and

1997. However, some thousands Rohingyas stayed back this time and some others joined them again fleeing from Myanmar. At this time, all camps in Bangladesh except two (at Nayapara and Kutupalong) were closed. These two camps are still present as registered camps (MSF, 2020).

From 1977 to 1991, the Rohingyas who entered Bangladesh were recognised as 'refugees' by the Bangladeshi government. However, after 1992, Bangladesh refused to recognise Rohingyas as refugees; Rather, they labelled them as "undocumented Myanmar nationals (UMN)'' or "unregistered refugees'' or "illegal migrants" to Bangladesh (UNHCR 2007, Bashar, 2012). In September 2013, the Bangladeshi government has acknowledged the presence of an estimated 300,000-500,000 "Undocumented Myanmar Nationals" or Rohingyas in Bangladesh through its first strategy paper titled "National Strategy on Myanmar Refugees and Undocumented Myanmar Nationals" (Abrar, 2014). However, of them, only around 30,000 Rohingyas were recognised as registered refugees (IRIN, 2013; Tan, 2013). From 1992 to 2016, no new camps were established although there was a steady Rohingya movement towards Bangladesh during this period. Then at the end of 2017, when more than 750,000 Rohingyas entered Bangladesh after the genocidal acts of Myanmar Army Tatmadaw (UNICEF, 2018; Haar et al., 2019), the Bangladeshi authorities had to establish 32 new makeshift camps in addition to the two already-existing registered camps to provide shelter to the Rohingyas (Rahman et al. 2021). During this time, the undocumented Rohingyas living outside of the registered camps also got shelter in the camps of the Cox's Bazar (Ullah et al., 2017).

Of the 34 camps of Cox's Bazar, the Bangladeshi authorities closed one camp at Shamlapur (Camp # 23) in Teknaf Upazila in 2021. The inmates of the camp were relocated to other

camps of Ukhiya and Teknaf (WFP Situation Report, December 2021; JRP, 2022). Thus, about one million Rohingyas, including 750,000 newly arrived, have been living in the 33 refugee camps of Cox's Bazar, Bangladesh (JRP, 2022). All the 33 camps are situated in the hilly area of Cox's Bazar, which is within three kilometres of the Bangladesh-Myanmar border. This border area is vulnerable and prone to individual and collective security threats (Thakur, 2022). As a result, the camps are under continuous surveillance of Bangladeshi security forces. Fencing around the camps and watchtowers have already been installed to increase surveillance of the Rohingya refugee camps (Sakib, 2021; Rahman, 2022a). There are paramilitary and Armed Police Battalion (APBn) check posts around the camps (Ashraf 2021). Law enforcing agencies also started to use drones to expand the scale of surveillance throughout the camp area (Sumon, 2022). In the refugee camps, the movement of Rohingyas are strictly restricted; they can only go outside of the camps for health or other emergency reasons, subject to prior permission from the camp authorities (Islam, 2021a). The Rohingya refugees are not allowed to travel anywhere, within or outside of Bangladesh (Azad, 2021).

Of the 33 refugee camps, 23 are located in the mega Kutupalong refugee camp network (largest refugee camp of the world). This camp network shelters over 600,000 of the roughly 900,000 Rohingya refugees (Akter et al., 2021; Biswas et al., 2021). Majority of these camps are located in Ukhiya Upazila (Bengali terms for subdistricts) of Cox's Bazar district housing over 80% of the Rohingyas in Bangladesh. The rest are living in camps in Teknaf Upazila (Biswas et al., 2021; Rahman, 2022b). To maintain the overall security of the camps, members of security forces (Bangladesh Army, Border Guard Bangladesh or BGB, Rapid Action Battalion or RAB) are deployed in the camp area and APBn are working to maintain the security inside the camps (Jinnat & Khan, 2020). The security agencies have set up at least 27 security checkpoints on the roads in and out of Ukhiya and Teknaf to prevent

Rohingya refugees from moving beyond the camp and to check outsider's entry/exit to and from the camps (JRP, 2018). Anybody's entry to any refugee camp of Bangladesh is highly restricted although at the initial stage of the camp formation in 2017, the entry was not controlled. Following allegations of entry into the camps without proper documentations, such as visa, work permit, official approval, the Bangladeshi authorities have restricted entry to the camps without proper permission since March 2018 (Rashid, 2018). Thus, accessing Rohingya refugees in the camps to collect data is a challenging job for by a researcher.

Ethical consideration

Before starting a fieldwork, a researcher should be aware of the ethical principles of a research. In any research, there are four main areas of ethical principles (Diener & Crandall, 1978) which are:

- whether there is *harm to participants*;
- whether there is a *lack of informed consent*;
- whether there is an *invasion of privacy*;
- whether *deception* is involved.

Bryman (2012) mentioned that in any research activity, ethics must be attributed in the way that no stakeholder should be harmed in the research process and researchers should keep in mind that they are not over-interpreting or misinterpreting the data. In refugee camps, especial ethical consideration should be taken by a researcher as the refugees are vulnerable people and the flow of refugees takes place in the "midst of complex emergencies" (Leaning, 2001; p. 1432) and the refugees in any host country enjoy minimum rights (Edwards, 2005). Until recently, there was no specific ethical guideline to conduct research in a humanitarian settings like refugee camps (Müller-Funk, 2021). There are some emerging literatures on

ethics in humanitarian settings but those do not have a practical, comprehensive set of guidelines on which inter-disciplinary and cross-sectoral consensus can be made (Clark-Kazak, 2019). In 2015-16 following the resettlement of some Syrian refugees to Canada, a broader Code of Ethics was developed by the International Association for the Study of Forced Migration (IASFM) and it has some key ethical principles to the specific contexts of forced migration (Müller-Funk, 2021).

Refugees are perceived by many host countries as 'illegal migrants', for example, the Rohingya refugees living in various countries. In this case, ethical considerations to safeguard the refugee right is a key to any researcher. In academic research, some ethical questions can be addressed through the respective university's ethics board procedure before data collection starts. Other issues that emerge during the fieldwork should be solved considering the circumstances of the situation. I learnt about the situations in the Rohingya refugee camps before starting the fieldwork. As a researcher with a background in communication and journalism, I oriented myself with the code of ethics of Massey University, New Zealand. Before leaving New Zealand to conduct the fieldwork in Bangladesh, I obtained full ethics approval from the Human Ethics Committee (HEC) of Massey University. This approval included respect and dignity of the participants, voluntary participation, participants' rights, safety of the participants and the researcher, and many other important ethical considerations. The ethics approval also examined other ethical issues regarding accessing, storing, retrieving data and anonymity of the participants. Ethical issues relating to Te Tiriti o Waitangi (The Treaty of Waitangi) are also addressed in the HEC review process of Massey University.

To conduct research in any refugee camp, the researcher should keep in mind that the research work may not create any situation that put the participants in further risk. Hugman et

al., (2011) argue that research with vulnerable populations like refugees may fail if they are left with further risk by the process of the research. To avoid this type of situation and to take appropriate ethical decisions, researchers have to fully understand the legal contexts in which refugee communities live. My work as a Journalist of Bangladesh Television (BTV) helped me a lot to know about the context of the Rohingya refugee camps. Before staring the fieldwork, I collected necessary information about the field from relevant government offices, Non-Government Organizations (NGOs), my personal networks and relevant scholarly articles relating to Rohingya refugee camps. Before leaving New Zealand for Bangladesh, I contacted one of my former colleagues of BTV in Cox's Bazar to know more about the context of Rohingya refugee camps and act upon the advice from him about how to fruitfully conduct my fieldwork at the Rohingya refugee camps. His advice helped me a lot as he has the field experience of Rohingya refugee camps.

Making trust with the research participants is one of the major ethical issues to collect data from the vulnerable population like Rohingya refugees. During data collection through in-depth interviews, the participants often provide personal information as they trust the researcher and with a hope that providing their present scenario may improve their situation, however, at one point they sometimes "find that their information is treated like a commodity" (Hugman et al., 2011, p. 1277). The refugee participants sometimes fade-up with the research works as Pittaway and Bartolomei (2003) in their research works in Thailand mentioned as refugee voice, "we are really fed up with people just coming and stealing our stories, taking our photos and we never get anything back, not even a copy of the report. Nothing ever changes (p. 36)." I must be prepared to handle this type of situation while collecting the data from the refugee camps of Cox's Bazar. In doing so, I followed the ethics of Culture-Centred Approach (CCA). CCA is a health communication methodology

that works through dialogue with the research participants so that the local meanings of participants' problems and probable solutions can be articulated and understood (Dutta, 2008). CCA believes listening as the main tool to know about the participants' lives and it argues partnerships of solidarity or trust with subaltern communities can be made through the concept of placing the researcher's "body on the line" (Dutta et al., 2019, p. 1). CCA also advocates placing the researcher's "body on the line" as a starting point to depict the ways of everyday meanings of life of the participants who live within the capitalist-colonial structures of humanitarian settings (Dutta et al., 2019).

Context of the study area

Geographical context

Among the 33 Rohingya refugee camps, 26 including the world's largest refugee camp at Kutupalong, are situated in Ukhiya Upazila and seven in the Teknaf Upazila of Cox's Bazar district. The district headquarters of Cox's Bazar is famous for its 120 km long seabeach. Most researchers stay in the Cox's Bazar town, which is 37 km or about a two-hour drive from the closest Rohingya refugee camp of Ukhiya Upazila (Akhter & Kusakabe, 2014). The researchers usually commute daily from Cox's Bazar to the Rohingya camps as there was no good accommodation facility near to the camp area (Shahabuddin et al., 2020). However, if anyone wants to stay for one month or more in the study area to conduct an ethnographic study, then it is not economically feasible to stay in Cox's Bazar as the town is as expensive as Dhaka, the capital of Bangladesh (Aziz, 2020). In this case, a researcher should try to find a suitable accommodation near the refugee camp area where he/she can also save the expenses of daily commute.

Weather/Climate context

Bangladesh is a country of six seasons but due to the rapid climate change and unplanned urbanisation, it is now a country of three seasons: a hot and muggy Summer (March- May), a hot rainy monsoon (June – October), and a warm-cool dry winter (November- February) (Sultana, 2019; Karim & Zhang, 2021). The entire Bangladesh including Ukhiya-Teknaf area is situated in the tropical monsoon region with broad seasonal distinctions in rainfall, high temperature, and humidity. Heavy rainfall is common in Bangladesh causing flood almost every year. As most of the Rohingya camps are built in hilly areas of Cox's Bazar, they are highly vulnerable to floods, landslides, and cyclones. In 2021, 30 of the 33 Rohingya refugee camps in Ukhiya-Teknaf were affected by the flash floods (Islam, 2021b; Patwary & Rodriguez-Morales, 2022). In Bangladesh, maximum summer temperatures range between 38 and 41°C (100.4 and 105.8°F). April is the hottest month in most parts of the country. December and January are the coolest months when the average temperature for most of the country is 16–20°C (61–68°F) during the day and around 10°C (50°F) at night. As many roads inside the camps are unpaved dirt roads, heavy rainfall creates miserable condition making movement very difficult. This condition seriously hinders any research activity during the rainy season. Considering other weather-related factors, such as high temperature during summer and monsoon seasons, winter and early spring (November to March) are the most suitable times to carry out any research activities in the Rohingya refugee camps of Bangladesh.

Access to study

Researchers require to obtain formal official permission from the Bangladeshi authorities before embarking on any research fieldwork at the Rohingya camps. Thus, before starting for Bangladesh from New Zealand, I contacted my former colleague stationed in Cox’s Bazar (local BTV correspondent) to help me obtain the official permission. He informed me that I had to apply in person to the Refugee Relief and Repatriation Commissioner (RRRC) office

situated in Cox's Bazar town. My initial plan was to visit the Rohingya refugee camp area in the middle of June 2021, but due to the Covid-19 pandemic, I had to reschedule my visit as at that time the Covid scenario was not very encouraging in Bangladesh. From New Zealand, I came to Bangladesh at the beginning of December 2021. Upon arrival in Bangladesh, I spent some days with my family in Dhaka. In the middle of December, I went to Cox's Bazar to obtain my permission from RRRC. I met one RRRC official and handed over my application. I had to apply as a Bangladeshi researcher. The RRRC official also asked about the objectives of my research and requested me to provide with the research questionnaire. During the meeting, I assured that my research had no direct political motive and not involved with any agenda that might be applied against the sovereignty or against the rules and regulations of Bangladesh. For foreign nationals, along with the application and questionnaire, photocopies of passport with visa page, two passport-sized photographs and proof or authentication from implementing agency/partner (copy of contract, appointment letter, ID, letter from concerned agency on official letterhead) are needed to get the camp pass (RRRC, 2021).

My appointment schedule with RRRC was confirmed by my BTV colleague in Cox's Bazar. Ensuring the help of a local contact is important for a researcher to get things going in an unknown or even a known place. Jenkins (2018) argued for communication with local contacts in a complex humanitarian setting to smoothly conduct any research. Before entering to the Rohingya refugee camp area, I had to stay in Cox's Bazar town for three days to get the official permission. Being a Bangladeshi citizen and aware of all the procedures, I got the permission document within the required three days of my application. However, the time required for obtaining the official permission may vary depending on the communication network of a researcher with the RRRC. In total, I spent 22 days in the field (Cox's Bazar town and Ukhiya) between December 2021 and January 2022 to conduct my PhD fieldwork.

Before my PhD fieldwork, I visited the Rohingya refugee camps two times. The first was in July 2018 as a BTV Journalist to cover the visit of the UN Secretary General Antonio Guterres who came to the Rohingya camps to see their plight and sufferings. The second was in February 2020, when I visited the camps to run a pilot of my PhD study before travelling to New Zealand.

Access to fieldwork

Accommodation in the field

Before travelling to Bangladesh from New Zealand, I contacted my former colleague at the Bangladesh Television (BTV) to find out a suitable accommodation near the refugee camp area. As stated earlier, the only state-own television service in Bangladesh—the BTV—was my previous workplace. I tried to utilize my personal connections to smoothen my fieldwork. With the help of my BTV colleagues, I managed an accommodation close to the refugee camps of Ukhiya Upazila in Cox's Bazar. Following my arrival in Dhaka from New Zealand, I also looked for someone who was known to me and working in Ukhyia. Luckily, I found one friend of mine who hailed from Patuakhali—my district of origin—and currently living in Ukhyia. He agreed to help me with data collection from the Rohingya refugee camps. It was my plan to stay close to the Rohingya refugee camps for making the data collection task easier. My plan worked when I managed an accommodation in Ukhiya Upazila and found a friend living there. The Kutupalong refugee camp network is located just a walking distance from my accommodation. Often, I took a Tom-Tom (local Bangladeshi autorickshaw) or bus to get to the camps. During my stay in Ukhiya for 19 days, I visited five Rohingya refugee camps and collected the primary data for my study.

Data collection procedure

The broader purpose of my fieldwork was to explore and understand the construction of health among the Rohingya refugees living in various camps of Bangladesh. These refugees have a documented history of health issues following resettlement in various camps of Bangladesh. To address the meaning of health of Rohingya refugees in the dominant discourse, the Culture-Centred Approach (CCA) was used to conduct the in-depth case study of the healthcare issues faced by these refugees. CCA is a health communication methodology having the tenets of structure, culture and agency (Dutta, 2008). In keeping with the tenets of CCA, in-depth interviews have been conducted among Rohingya refugees living in camps of Bangladesh to facilitate the emergence of concepts of health from the ground up through engagement with the participants. In the in-depth interview process in CCA, participants lead the dialogue, where the role of the researcher is to listen to their narratives and then place those stories from the margins in the dominant communication narratives. Here, the researcher works an active listener, encouraging the participants to present their narratives of lived experiences by using follow-up questions and probes. In CCA, most of the questions are kept open-ended, grounded in explorations of the meanings of health and wellbeing in the lives of Rohingya communities. In in-depth interviews, open-ended questions create an environment where interviewees "feel relaxed and unassessed" while expressing their opinions to the researcher (Hannabus, cited in Sandy & Dumay, 2011, p. 245).

During my fieldwork, I engaged with the Rohingya refugees living in the old Kutupalong RC (Registered Camp) and four other camps of Ukhiya Upazila. In most of the days, I left my accommodation at 9 O'clock in the morning and spent the next six hours to collect the data. In the permission letter, The Bangladeshi authorities mentioned that I had to leave the refugee

camps before 3:30 pm every day. They also mentioned that no fieldwork could be carried out during weekends or public holidays (Fridays and Saturdays are the weekly holidays in Bangladesh). As mentioned earlier, I could start my visit inside the refugee camps of Ukhiya Upazila only on the fourth day of my tour to Cox's Bazar. On a sunny Sunday morning in December 2021, I along with my friend (who lived and worked in Ukhyia) and a Rohingya interpreter entered a Rohingya refugee camp of the mega Kutupalong camp network after showing our camp permission letter to the officials at the Camp-In-Charge (CIC) office. The CIC is a Bangladeshi government official in charge of the camp (Amnesty International, 2020). Lately, the Armed Police Battalion (APBn) personnel patrol the main gate of each camp. At the time of our entrance, the APBn police stopped and asked us about the purpose of our visit to the camp and allowed us to proceed towards the CIC office.

Interpreter and sample selection

After confirming my accommodation in Ukhyia Upazila, I made an appointment with my friend living there to seek his help with finding a suitable Rohingya interpreter. The Rohingya language is quite different from Bangla language but has some similarities with the Chattogram dialect of the Bangla. If a Bangladeshi does not speak the Chattogram dialect, it is fairly difficult for her/him/them to understand the Rohingya language. I requested my friend to find out an interpreter who knows Bangla and Rohingya languages fluently and familiar with the camp area. As my friend had been living in Ukhiya Upazila for more than five years, it was easy for him to find an experienced Rohingya interpreter. My interpreter was a Rohingya who came to Bangladesh during the 1991-92 exodus. The interpreter's role was to translate my open-ended Bangla language questions into Rohingya language for the participants and then convert the answers of the participants into Bangla language for me. In this study, I used a purposive and random sampling method to select my interview participants. I selected Rohingya participants randomly because the research questions do not

suggest any specific categories of people, rather broadly the Rohingya refugee participants. I told my interpreter that both male and female Rohingya refugees, new arrivals (who came to Bangladesh in 2017) and old refugees (who came before the 2017 exodus), were acceptable for the purpose. Thus, the samples were chosen randomly and yet relevant to my research.

The main criteria for the participation in the in-depth interview was that the participant should be 18 years or older and living in one of the Rohingya refugee camps of Cox's Bazar. For formal consent, the participants were requested to sign a consent form. However, since literacy rate is low in the Rohingya population, some participants were unable to sign the consent form. In those cases, I sought verbal assent and consent from the participants. An audio tape recorder was used for recording the qualitative interviews so that full and intact thoughts of the participants can be retrieved and used in the study. I read out and explained in detail the objectives of the interview to the participants. The interpreter translated it where required. During the in-depth face-to-face interviews, I asked open-ended questions to the participants. Still, I used a pretested semi-structured questionnaire in the Bengali language for my reference guide in this information collection process. The duration of the in-depth interviews or discussion sessions ranged from 40 to 90 minutes. During my entire fieldwork, I took 41 in-depth interviews. Of the respondents, 20 were male and the rest 21 were female Rohingya refugees.

Strategy adjusted

For the first two days of my fieldwork, my friend, the Rohingya interpreter, and I showed our camp pass document to the APBn police at the camp entrance and went to the CIC office, introduced ourselves and showed the camp pass document again to him. The CIC asked me whether I would like to conduct the in-depth interview in and around the CIC office area or

visit the camp area. I responded that I would like to visit the camps and then conduct the in-depth interviews at the participants' shelters. The CIC agreed but provided us with a representative (Rohingya volunteer) who would help to find the participants. While conducting the interviews, I noticed that the Rohingya participants were not comfortable in sharing their lived experiences, feelings etc. in front of the CIC representative. So, after two days, I decided to change my data collection strategy in the Rohingya camp area. The rest of the days of my fieldwork, I showed my camp pass document to the APBn police at the entrance and straight entered into the camp to find out the Rohingya participants myself. As my interpreter was also a Rohingya, who came to Bangladesh in 1991, he could easily find and select the right participants of my interviews. I could find out the Rohingya participants easily as most of the male Rohingyas stayed in the shelters as they were not allowed to go outside the camps and did not have a job inside. The female Rohingyas were somewhat busy with their household chores or childcare responsibilities, but still granted me some time to share their life story.

After entering each camp, the researchers generally communicate with the Majhiis (the local Rohingya leaders), explain him (almost always the Majhis are male) the purpose of the study. Then with the Majhi's support, a researcher may find out respective Rohingya participants and get access to their shelters. Accordingly, at the beginning of my study, I tried to find out the Majhis to conduct my in-depth interviews. However, it is time consuming to find a Majhi every day. In addition, a researcher would need to seek help from the CIC to find out the Majhis on every occasion. I also noticed that some Rohingya participants did not have confidence in their camp Majhis and considered them as a part of the power dynamics. As a consequence, the respondents felt shy about describing their sufferings to me. So, after two days of my fieldwork inside the camp, I stopped searching for the Majhis when I entered a

camp area. Rather, with the help of the Rohingya interpreter, I tried to find out and select the participants myself. This strategy has enabled us to successfully conducted the fieldwork.

To interview female Rohingya participants, I planned to recruit a female Rohingya interpreter. However, I could not manage to recruit any because the female Rohingyas reasonably strictly maintain the Muslim tradition of purdah and not interested to go outside of their shelters. Moreover, most of them do not know the Bangla language very well. As a result, I had to rely on my male Rohingya interpreter to conduct the female Rohingyas' interview. With his assistance, I successfully managed the interviews of the female Rohingya refugees. During these interviews, the male Rohingya interpreter usually sat beside the female as they belonged to the same community, and I took my seat in the distance so that the female can maintain her purdah. Being a Bangladeshi Muslim also helped me to understand the Rohingya Muslim culture. For example, while entering into any shelter, I usually used the Islamic greeting of saying "Assalamualaikum" (Peace be upon you), a religious cultural convention understood and widely used by Muslim Rohingyas. I also mentioned our identity and purpose of visiting the shelter. Then we tried to build up the trust among the potential Rohingya participants and started our conversations.

COVID-19 safety protocols

Once my PhD enrolment was formally confirmed in April 2021, I planned to start my fieldwork as soon as possible. In New Zealand, the researchers generally go to the field to collect primary data following their PhD confirmation. However due to the Covid-19 pandemic worldwide, specifically in Bangladesh's refugee camp area, I could not start my fieldwork immediately after my PhD confirmation. Then in early December 2021, when the Covid-19 scenario in Bangladesh improved with the infection rate of less than 2%, I travelled

from New Zealand to Bangladesh. I think I was the luckiest of some researchers who could complete primary data collection through fieldwork during the Covid-19 pandemic period (2020 to 2021). However, during the interviews, I could not maintain the suggested protocol of two metres social distancing as it was virtually impossible in the congested refugee camps. I followed other more realistic and pragmatic health safety protocols, such as wearing of masks. My interpreter and interview participants also used masks during the entire period of interviews.

Recommendations

The general aim of a research in humanitarian settings (e.g., in a refugee camp) is to find out the challenges of vulnerable people living there and inform the world of the challenges. It is also aimed at raising awareness and taking appropriate steps by the stakeholders to mitigate the challenges and improve their living conditions. However, researchers often face challenges in conducting research in such humanitarian settings. Developing an advanced level of understanding of the challenges can enable researchers to adopt appropriate strategies before commencing the study. Based on my fieldwork experience in the Rohingya refugee camps of Bangladesh, some suggestions are discussed below for the benefit of future researchers.

- Researchers should start planning first and communicate with the relevant stakeholders to know about the context of the field,
- Carefully considering the geographical context of the camps and seasonal variations including rainfall is very much needed. Finding out the right season for the task is important. In my case, the dry season (from November to February) was the best time to conduct any research activity at the Rohingya refugee camps,

- Sometimes an initial visit or pilot study to the camps and interviews with various stakeholders may help,
- Accommodation is a vital component in an ethnographic study. Thus, researchers should think about the accommodation in advance so that he/she can easily find the living spot near the fieldwork,
- Special attention needs to be paid to get the camp pass to access into the refugee camps,
- Researcher should adopt different strategies for dealing with different authorities. For example, I adopted an inclusion strategy for the RRRC and CIC, but kept my strategy open (i.e., both inclusion and exclusion strategies) for gatekeepers, such as Majhis and camp site management authorities,
- Recruiting interpreters from the study community is very much helpful in establishing a positive connection and appropriate communication between the researcher and respondents. In this regard, gender sensitivity can be an important consideration. For example, a female interpreter would be more helpful than a male interpreter in collecting data from female participants,
- A Researchers should be respectful to the culture, religion, choices, and privacy of the participants,
- A researcher should be ready to put her/his/their "body on the line" of the respondents' struggle to know about their lives.

Conclusion

This article finds relevant challenges and adaptation strategies of a fieldwork in a humanitarian context like the Rohingya refugee camps of Bangladesh. The multi-level complexities of a refugee camp may introduce unforeseen challenges and interrupt research

plans but overcoming those challenges collecting data from the vulnerable communities is the is the main responsibility of a researcher. Contextual and time bound adaptation of strategies are the key lessons learnt from the study. The lessons learned from this study will be very useful for sensitizing future researchers about the underlying issues of a refugee camp. This might be useful to draw a parallel study in a different setting of refugees and/or displaced communities living in other parts of the world.

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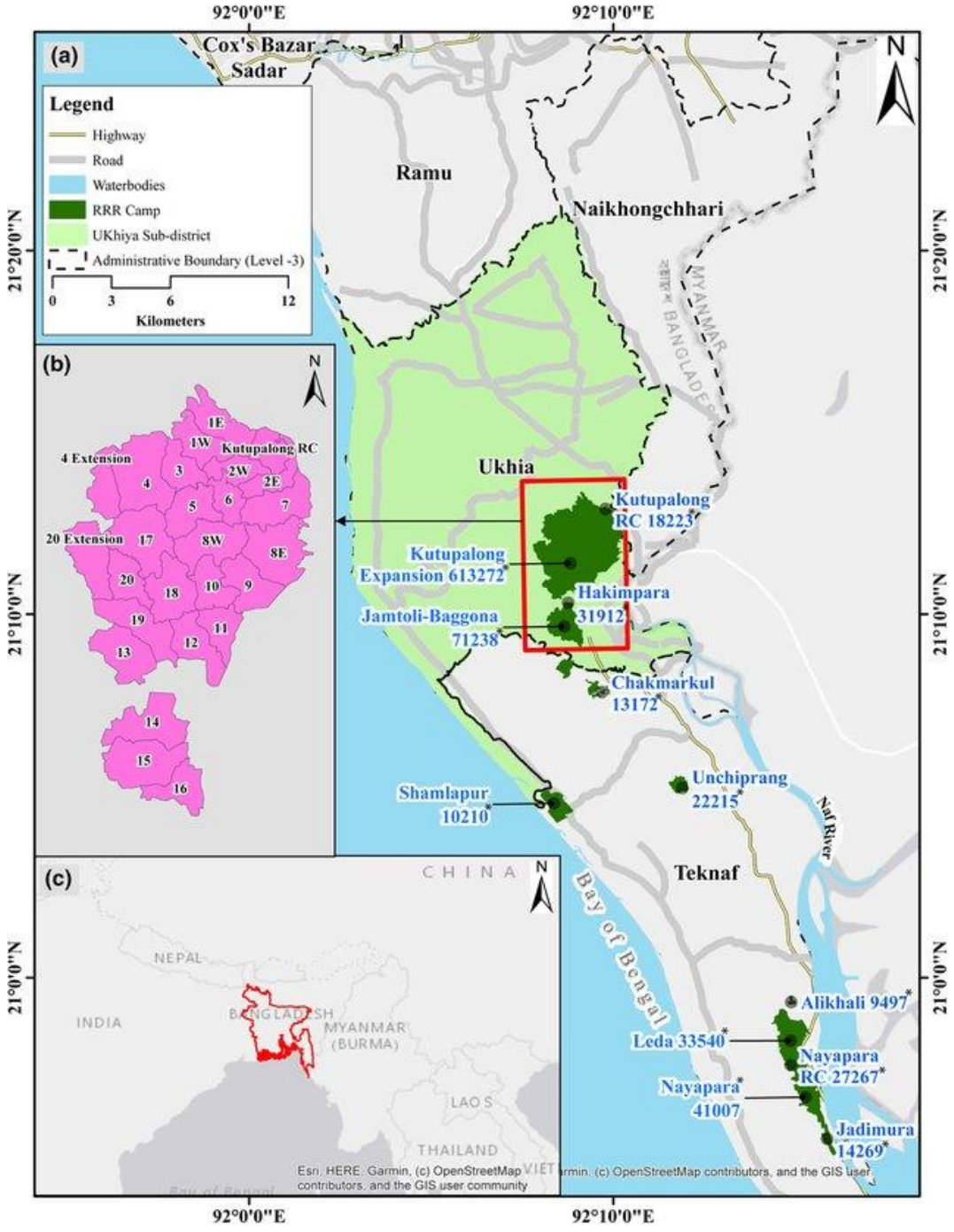
4.4 Study area

I selected my study area where most of the Rohingya refugees have been living following the 2017 exodus. More than 700,000 Rohingya refugees have temporarily settled in Ukhiya upazila since August 2017 (Quader, 2019; Prodip, 2023). Since about 80% of Rohingyas in Bangladesh live in Ukhiya, I have chosen this upazila as my study area. Ukhiya is one of the eight Upazilas (sub-districts) of Cox's Bazar district with an area of 261.8 sq. km (ADB Project, 2019). The name of the eight upazilas of Cox's Bazar district are: Chakaria, Cox's Bazar Sadar, Kutubdia, Maheskhali, Pekua, Ramu, Tekhnaf, and Ukhiya (Biswas et al., 2021). Ukhiya is located in between 21°08' and 21°21' north latitudes and in between 92°03' and 92°12' east longitudes (see Map 1.6). It is surrounded by Ramu upazila on the north, Teknaf upazila on the south, Rakhine state of Myanmar and Naikhongchhari upazila on the east, the Bay of Bengal on the west (Quader et al., 2019). Ukhiya was established as a thana in 1926 and became an upazila in 1983 (Mukherjee et al., 2022).

Ukhiya upazila is located some 37 kilometres south of Cox's Bazar Town (Akhter & Kusakabe, 2014). This area is characterised by diverse physiography, such as rolling hills, piedmont plains, tidal floodplains, and a continuous line of sandy beach known as Inani beach that extends to Cox's Bazar (Bappa et al., 2022). Ukhiya is also under the tropical monsoon climate; heavy monsoon rainfall usually starts in early July and continues for 2-3 months. During this rainy season, a threat of a potential flood and landslide always looms in Ukhiya and other areas of the Cox's Bazar district (Acaps, 2018b; Hossain, 2019). The largest refugee camp of the world – Kutupalong mega camp – is situated at the Ukhiya upazila of Cox's Bazar. See Map 1.6: Ukhiya upazila of Cox's Bazar.

Map 6: Ukhiya upazila of Cox's Bazar



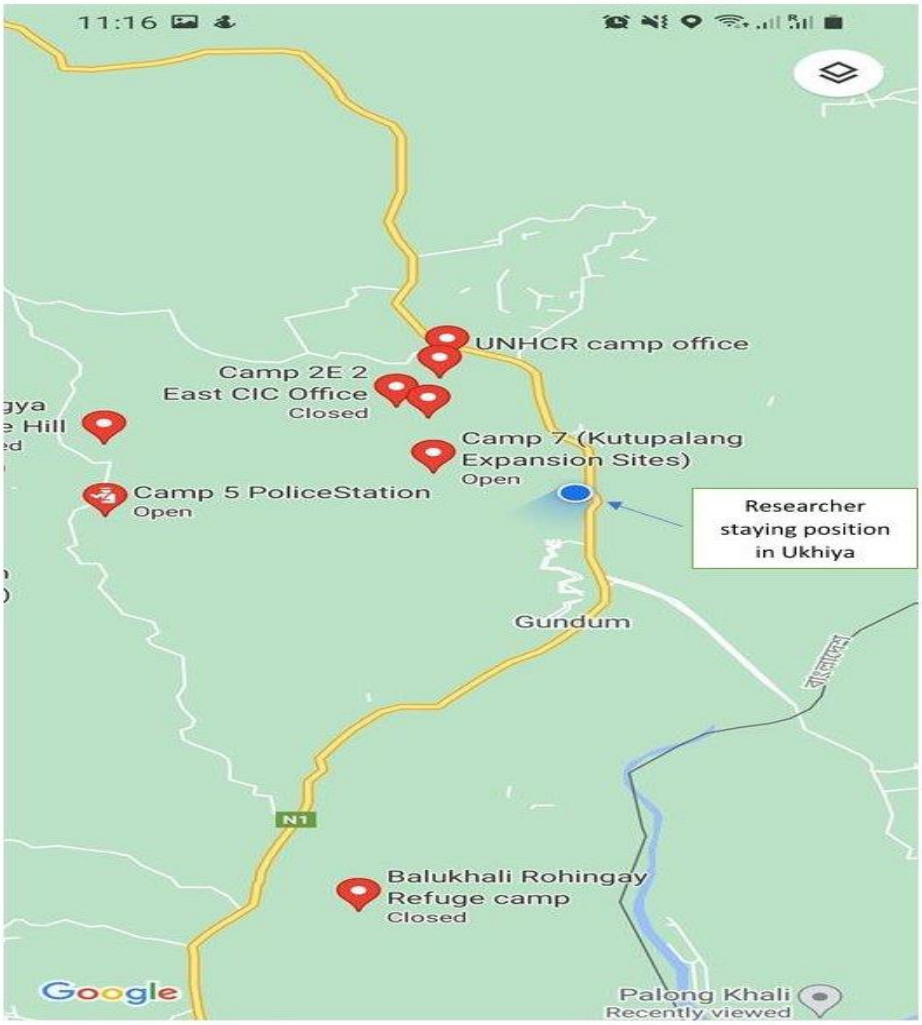
Source: https://www.researchgate.net/profile/Md-Malak/publication/341772560/figure/fig1/AS:946681210208257@1602717797773/The-map-a-showing-the-location-of-Ukhiya-sub-district-and-refugee-camps-with-the.ppm

The map (a) showing the location of Ukhiya upazila (light green); (b) The inset map represents the Kutupalong expansion site with the camp number. (c) The inset map shows the location of Bangladesh (denotes in red colour).

4.5 Study site

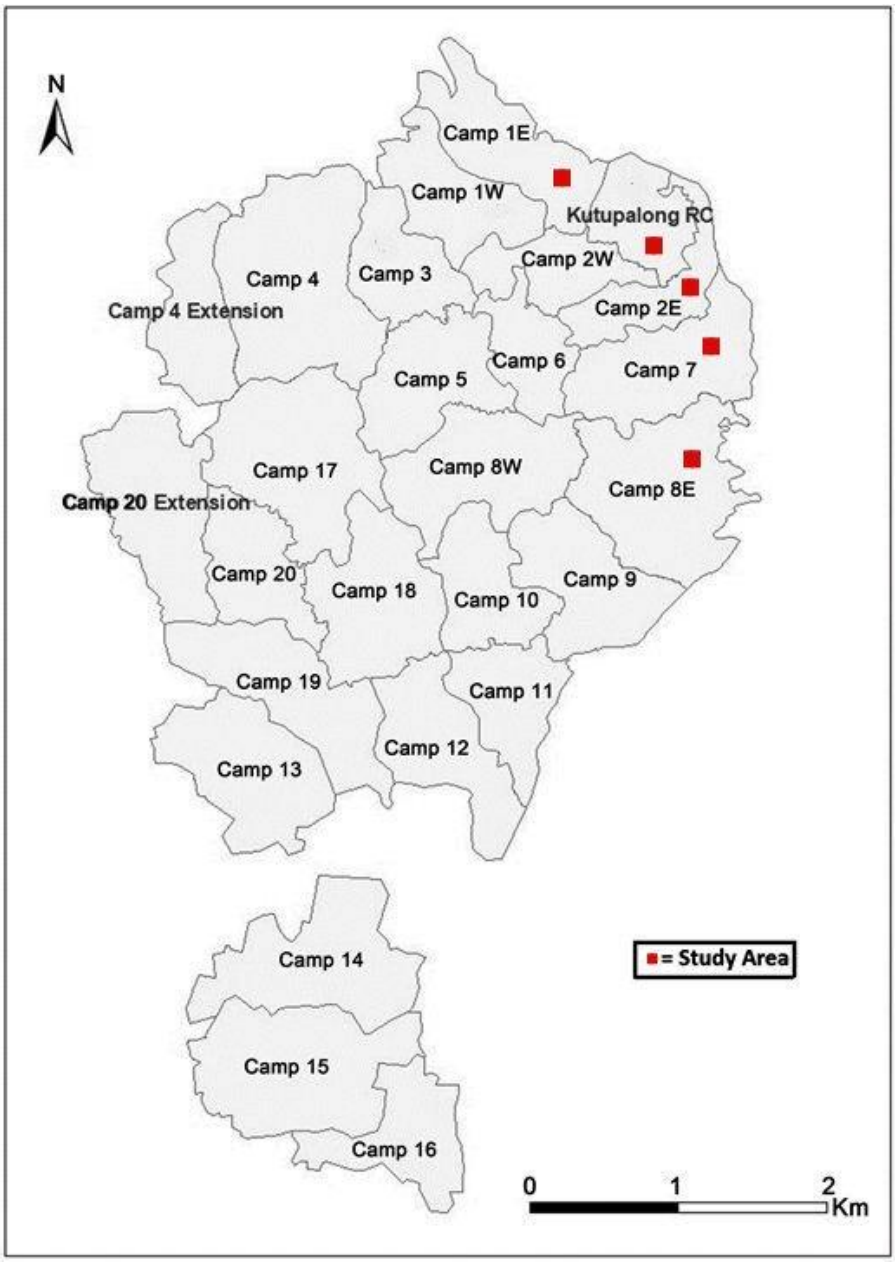
As mentioned earlier, the fieldwork for the study was conducted at several Rohingya refugee camps situated in the Ukhiya upazila of Cox's Bazar district. Out of the 26 camps in Ukhiya, five were selected in this study by considering factors including their geographic locations, accessibility, availability of infrastructure et cetera. In the figure below, I indicated the location of my accommodation using the Google Map (Figure 12). As I had been staying very near to Camp 7, I went to that camp first to conduct the interviews.

Figure 12: Researcher accommodation at Ukhiya (spot taken by author through Google Map)



Besides Camp 7, I also visited Camp 2E, Camp 8E, Kutupalong RC (RC=Registered Camp) and Camp 1E (Figure 13). I also visited 'Hindu Para' (outside of camp 1) where some 500 Hindu Rohingya refugees had been living since August 2017. This specialised area had been allocated to the Rohingya Hindu families since they faced some problems living amongst the majority Muslim Rohingya refugee population.

Figure 13: Study sites (Camp no.)



Source: https://www.scirp.org/journal/paperinformation.aspx?paperid=97839

4.6 Rohingya Participants

The population of the study consists of adult Rohingya refugees (i.e., 18 or above years of age) who had been living at the camps for years. The Rohingya translator/interpreter, who may be identified as a Community Researcher under CCA provisions, helped me to find my research participants considering their gender, age, diverse experience etc. Methodologically, I used an applied referral method as well as snowball sampling to find out my targeted Rohingya respondents. I conducted 41 individual in-depth interviews including five focus group discussions (FGD) with Rohingya refugees. Altogether, 19 male and 22 female Rohingyas participated in the individual interviews. The table below outlines the basic demographic characteristics of my participants in Bangladesh; it includes their gender, age, location and status of participation in individual interviews and FGDs.

Table 4: Basic demographic characteristics of Rohingya participants

Location		**Male**		**Female**		
Sl.		Age (yrs)	Entry Year in Bangladesh	Sl.	Age (yrs)	Entry Year in Bangladesh
01	**Camp 7**	43	2017	01	42	2017
02		27	2017	02	25	2017
03		27	2017	03	30	2017
04		22	2017			
05		27	2017			
				Participants in FGD (3 neighbours)		
				04	32	2003
				05	42	2005
				06	55	2017
				Participants in FGD (Husband-wife)		
06		42	2017	07	31	2017
	Kutupalong			08	57	1991

	RC			09	22	Born in BD
				10	23	Born in BD
				11	24	Born in BD
				12	19	2012
07	**Camp 8E**	36	2017	13	32	2017
08		76	2017	14	62	2017
09		45	2017			
10		64	2017			
11		21	2017			
	Participants in FGD (2 participants)					
12		38	2017			
13		34	2017			
14	**Camp 2E**	77	2001	15	25	2012
15		66	2012	16	22	Born in BD
16		25	2008	17	21	Born in BD
				18	23	Born in BD
				Participants in FGD (3 sisters)		
				19	20	2017
				20	22	2017
				21	28	2017
17	**Camp 1E**	60	1991	22	36	1991
	Camp 1 (Hindu Para)					
	Participants in FGD (11 participants) Taking group leader demographics					
18		37	2017			
19		56	2017			
19 Male participants				**22 Female participants**		
Total 41 participants						

The total number of participants was 41 including those who took part in FGDs. The FGDs may be called “group interviews” as the situation at that time of interviews compelled me to

run the interviews in a group. For example, in the first FGD, three females took part who were neighbours and unwilling to talk individually. In the case of the Camp 2E's FGD where three sisters participated, the same scenario occurred. Also in Hindu Para, when I met the participants, they were playing cards together. I requested them to take part in the discussions and they agreed. At the end of a FGD, I noted the demographic info of all participants. However, this could not be done in the case of the Hindu Para FGD. At this Hindu Para FGD, which was the most fruitful in my view, I was only able to note the group leader's demographic information. Due to this, I counted the FGD as one participant. Of the total 41 participants, there were four majhi participants who were all male.

4.7 Data collection techniques

A semi structured questionnaire in Bengali language was used to collect research data through face-to-face interviews with the Rohingya participants. The term 'semi-structured' refers to a practice where the researcher has a set of written questions based on several themes for the purpose of information collection through interviews, but the actual interviews do not follow the order or exact wording of the written questions. For my purposes, I also prepared a set of interview questions based on a review of related literature on Rohingya health. The questionnaire was developed originally in English language and then translated into Bengali language (Please see the interview protocol in Appendix A). It was not translated into the Rohingya language since the language lacks an appropriate written form. Moreover, the majority of the Rohingya refugees living in the camps are illiterate. I asked the questions to the Rohingya people in Bengali and the translator/interpreter translated them into the Rohingya language. The participants answered them in the Rohingya language that was again translated to me by the translator/interpreter. However, some of the Rohingya

participants could answer the questions in Bengali, which was convenient for me as my mother tongue is Bengali. The entire interview sessions were audio-recorded for accuracy. As the translator/interpreter was a Rohingya, I noticed that the Rohingya participants felt comfortable speaking openly and sharing issues of their personal lives related to health concerns.

The semi-structured in-depth interviews took place at different blocks of the camp. Interviews were conducted in a quiet room of the shelter/house of the respective refugee participant situated in a particular block of the camp where only the researcher and the translator/interpreter were present. The translator/interpreter who is also known as community researcher in CCA, generally obtained permission from the Rohingya participants beforehand to ensure that the respondent would be free and comfortable to talk and share their life stories. Before starting the in-depth interview, the purpose and confidentiality of the study were clearly explained to the respondents. Privacy and confidentiality were always ensured during the data collection process. Each interview or FGD was conducted while sitting on the dirt floors of different temporary bamboo structures the Rohingya refugees called home. I sat with an audio recorder and asked questions in Bengali, which was translated into Rohingya language by the interpreter. Then, the respondent shared their responses, which were translated back into Bengali language by the Rohingya interpreter.

Before starting an interview, all participants were requested to sign a consent form (Appendix B). As most of the Rohingya refugees are illiterate, I recorded verbal consent for those who could not sign the consent form. At the end of the interviews, I filled out a demographic sheet (Appendix C) for each participant by asking the questions listed in the sheet. I also encouraged face-to-face interviews for the Rohingya participants to share their healthcare

experiences where anonymity and confidentiality were ensured. I made sure human ethics and other ethical protocols were strictly maintained to keep the participants' identity hidden (see section 4.9, 'Ethical Framework' in this chapter).

The 41 qualitative in-depth interviews helped me to understand the meaning of health to Rohingya refugees or the process they used for receiving health services at the camps. During the interviews and FGD, I also conducted participant observation that worked as evidence of deeper understanding (Tracy, 2010). The level of comfort of the participants while sharing their lived experiences also increased the data rigour (Kumar, 2011). Although I employed different data collection strategies, such as focus groups, participant observation, field note taking; the semi-structured face-to-face interviews allowed me flexibility to explore research issues effectively throughout the whole process of my research. The semi-structured one-to-one in-person in-depth interviews were very effective in my study. They helped me to maintain the smooth flow of discussion but, at the same time, allowed the participants to freely ask any questions so as to ensure a knowledge sharing mechanism during the interview sessions. This openness of the discussions enabled the Rohingya participants to articulate the meaning of health and wellbeing together with challenges and solutions.

4.7.1 Tools used in data recording

This research was conducted primarily on the basis of the interview excerpts and other information provided by the interviewees. In this regard, my field notes worked as an important source of data recording. However, my principal data collection technique was in-depth interviews where I tried to find out the overall knowledge, beliefs, and interpretations of health seeking behaviour of the refugee inmates in the study area. I used a digital audio

recorder for recording the entire interview process. So, the major tools of data recordings were:

✓ Digital audio recorder

✓ Field notes

4.8 Analysis strategy

All the 41 in-depth interviews had been audio recorded using a digital audio recorder. I transcribed all the interviews and FGDs and later translated them from Bengali to English. I transcribed all the interviews in full, which was time consuming yet quite helpful for me to relate to the events that have been stored in my memory. The fieldnotes taken during the fieldwork supplemented and enriched the interview and FGD data. A digital audio recorder cannot record the facial expression, body language, or gesture of a participant. The fieldnote included all these elements. The fieldnotes helped me to find out the rich and subtle health meanings of the Rohingya participants. It helped me to identify the patterns I saw in my participants' expressions and experiences, links between these experiences, and similarities and dissimilarities of health experiences between individual participants during the interviews and among the group members during FGDs.

4.8.1 Translation strategy

Although I have basic language skills and an understanding of the Rohingya language, I still recruited a Rohingya interpreter to ensure the flow in conversation during the in-depth interviews. The need for an interpreter was even more essential, as the language skills of the

Rohingyas, who have learned Bengali (Bangla) language, were limited and came with different accents and dialects. However, using an interpreter can be challenging, and information and detail can be lost in the transcription, especially with several links in the translation chain. Although the translation has been done by me, there are several other challenges that can crop up while using an interpreter for the interviews. I used three different interpretations (i.e., translation/ transcription) in the same contexts, as some interviews were translated from Rohingya to English, and some from Bangla to English, but the majority were from Rohingya to Bangla to English.

For the qualitative data originating in a language other than English, translation accuracy is very important as variation among translators and translations may change the original meaning (Clark et al., 2017). During the recording of the interviews two stages of translation took place i.e., the Rohingya participants engaged in the discussion generally in the Rohingya language and then that was translated by the interpreter into Bangla language. As I am competent in both Bangla and Rohingya language, I could find out if the interpreter properly translated the responses into the Rohingya language, not affecting the true meaning of the responses. To ensure data accuracy of the translated transcripts, I utilised my familiarity with the language and cultural context of the Rohingyas in which the study took place in reviewing transcripts for any discrepancies (Clark et al., 2017). Besides, I have had working experience with the Rohingya refugees for more than six years and also continue to deal with former Rohingya refugees living in New Zealand. These background and ongoing engagements made me confident about the quality of the translation of the interview transcripts.

In addition to my familiarity with the Rohingya language and culture, my supervisor Prof. Mohan Dutta, who is also familiar with the cultural context of Rohingya refugees, reviewed the transcripts for any discrepancies. Due to time constraints in the field (as I had been permitted to stay and work in the camp areas for only 22 days), it was not possible to check the translation of all of the interview transcripts with the interpreter. Later, however, the review of this sample of transcripts indicated that there were no language issues in the transcript.

4.8.2 Data saturation

I conducted 41 in-depth interviews of Rohingya refugees living in the various camps. This sample size was guided by data saturation. Saturation is attained when no additional data are being found from the participants; that is, when replication rather than extension of data occurs (Strauss & Corbin, 1998). According to Grady (1998), "in interviews, when the researcher begins to hear the same comments again and again, data saturation is being reached…. It is then time to stop collecting information and to start analysing what has been collected" (p. 26). Saunders et al. (2018), exploring various examples in the literature, proposed three issues related to saturation:

"(1) 'What?'—in what way(s) is saturation defined?
(2) 'Where and why?'—in what types of qualitative research, and for what purpose, should saturation be sought? and
(3) 'When and how?'—at what stage in the research is saturation sought, and how can we assess if it has been achieved?" (p. 1894).

In this research, I observed three avenues of recognising that data saturation was being achieved. First, while conducting the interviews, the Rohingya participants' narratives were constantly monitored with the intention of spotting potential differences and emerging aspects in the data stream, keeping the scope and domain of the research in mind. The two remaining indicators were observed in parallel, either on the day of the interview or the next day, while the interview remained fresh in my mind. The second approach involved familiarisation with the data by listening to each recorded interview with the intention of identifying emerging themes. The third way of spotting potential data saturation consisted of summarising key points, while and after listening to the interview, to notice both emerging and repeating issues. Therefore, further interviewing was stopped when participants' stories did not noticeably differ in terms of any of the key targeted research topics (the struggles Rohingyas faced due to socio-cultural norms, nature of their daily lives, the contribution from the Bangladesh government and international agencies, and how they configure health through various activities).

4.8.3 Analysis technique

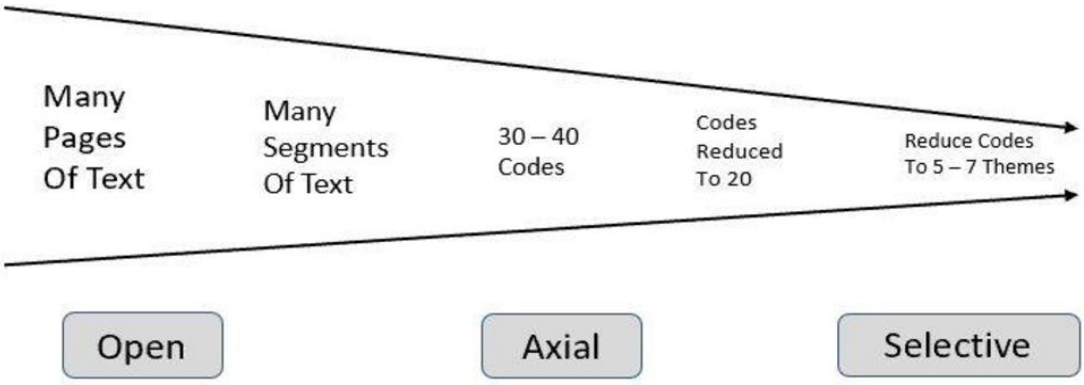
In this study, the 41 audio-recorded in-depth interviews were translated and transcribed into English text by me. After getting the English texts of the in-depth interviews, the next step was thematic analysis of the texts. I utilised the grounded theory (GT) to analyse the data. Two American sociologists Barney Galland Glaser (1930-2022) and Anselm Leonard Strauss (1916-1996) are considered the founders of grounded theory in the social sciences (Glaser & Strauss, 1967). One of the main characteristics of grounded theory is that it tries to generate theory that is grounded in the data or in the real-life experiences of the participants (Rieger, 2019; Chun Tie et al., 2019). GT is considered one of the most popular research designs that

includes data collection, saturation, analysis, categorising, coding, constant comparison, comparing, generating theory (Elliott & Lazenbatt, 2005; Glaser & Strauss, 1967; Urquhart, 2013). The main target of GT is to develop theory, which is achieved by applying coding processes efficiently (Vollstedt & Rezat, 2019). In Culture-Centred Approach, the analysis is generally done by constructive grounded theory approach as this approach works through the dialogue between the participants and the researcher and CCA is "related to engaging the local narratives with the emerging theoretical frameworks" (Dutta, 2012, p. 372). CCA believes that "researchers spend adequate time learning about the cultures and immersing themselves within these cultures and their politics in order to better develop applications and assessment tools on one hand and build lifelong friendships based on understanding via dialogue on the other" (Dutta-Bergman, 2004a, p. 242).

In GT, a thematic method of data analysis is used to create major themes and sub-themes of the research questions based on the coding schema (Kumar, 2011). In qualitative research study, data analysis actually begins by the coding of data (Charmaz, 2000; 2014). Coding is a process where micro analysis of word-by-word data is carried out by the researcher (Bryman, 2012). The most-used coding process of grounded theory consists of three stages: open coding, axial coding and selective coding (Bryman, 2012; Strauss & Corbin, 2008). In open coding, researchers analyse the data from all possible angles, break the data into discrete parts, and create "codes" to label them. Open coding is done with line-by-line reading of the texts where concepts and key phrases are identified (Mohajan & Mohajan, 2022). In axial coding, the researcher begins to draw connections between the codes and tries to group codes that share a relationship. To further organise and categorise data at the axial coding stage, some researchers choose the six C's model: causes, contexts, contingencies, consequences, covariance and conditions; for further organising and categorising data (Williams & Moser

2019). Thus, axial coding helps to identify key themes, subthemes, and the underlying structure or framework that emerges from the data. The final step of coding in GT is the selective or theoretical coding that explores how the relationships between the codes come together, to identify a core category or central theme that captures the essence of the research (Williams & Moser 2019). Figure 14 shows the Coding pattern.

Figure 14: Overview of coding process: Open, Axial and Selective Coding

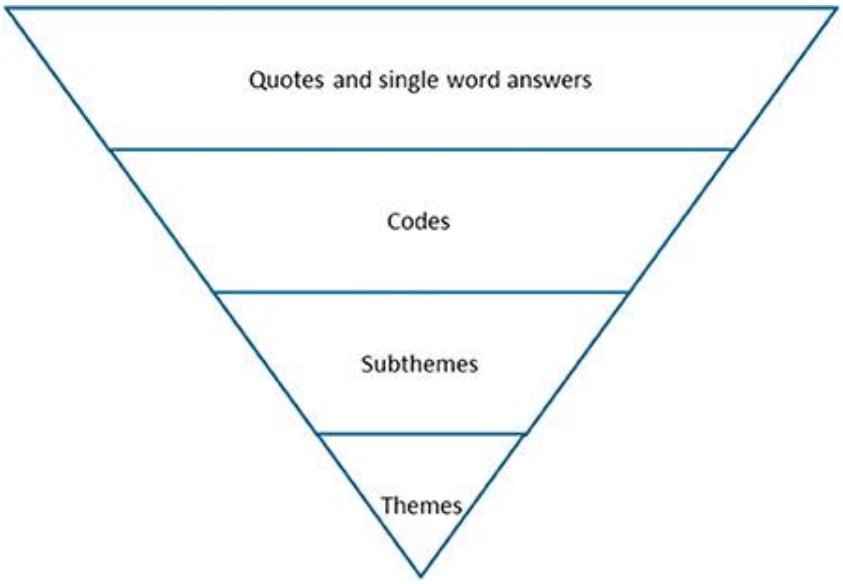


Source: http://www.imrjournal.org/uploads/1/4/2/8/14286482/imr-v15n1art4.pdf

Given the volume of fieldnotes, interview transcripts, participant observation, camp pictures, and other documents, I conducted multiple readings to familiarise myself with the data. I followed three sequential types of coding, 'initial coding,' 'axial coding,' and 'selective coding' to analyse the data. At first, initial coding was undertaken by me by line-by-line reading of the texts which helped to get fresh ideas and concepts on the data, and then through 'axial' and 'selective coding,' the sub-themes and themes were selected (Charmaz &

Bryant, 2011). Through constantly comparing ‘data with data, data with codes, codes with codes and codes with tentative categories and categories with categories’ the ultimate sub themes and themes emerged (Braun & Clarke, 2006) and the themes and sub-themes were utilised by me to write the articles. The theoretical framework of information developed by the process of analysis based on grounded theory became the underlying themes, which reflected the formation of findings and analysis chapters that follow. Figure 15 shows qualitative steps of my analysis.

Figure 15: Qualitative steps of Analysis



Source: https://www.frontiersin.org/articles/10.3389/fpsyt.2022.922788/full

For analysis, at first, various codes, like codes relating to food, food ration, same food, daily food, limited food, staple food, ration card, same curry, food shortage, buying food etc were identified by me. Then I compared these codes with other codes, codes with data, codes with categories and identified sub-themes like inadequate access to food, shortage of food, limited

curry item, selling food item, monotonous daily food, not able to buy food. Then these subthemes are combined together to find a theme that is utilised to write an article. For example, to write article on insufficient food ration titled "Living through food rations: A culture-centered study with Rohingya refugees" I utilised three themes which are: (1) inadequate access to food, (2) monotonous and culturally inappropriate food, and (3) resorting to selling food.

4.9 Ethical Framework

Research with refugees always poses ethical challenges because of unequal power relations, a legal identity crisis, and intense poverty experienced by the respondents living in the refugee camps (Müller-Funk, 2021). To address these issues, the Culture-Centred Approach proposes a model whereby researchers showing solidarity with the participants engage in an ongoing process that aims to develop a shared understanding of all aspects of the research project (Dutta et al., 2012). However, showing solidarity sometimes creates the expectation by the participants that the researcher may be able to help the participants to find a solution to their crises or to help them directly by other means (e.g., financial help). However, I remained true to the objective of the research that tries to expose the situation of vulnerable people to the world to raise awareness and encourage the international community to come forward (Austin & Sutton, 2014). I briefly discussed ethical challenges and moved onto the ethical procedures I followed in my study in the published article (at 4.3.3) titled "Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh."

This project has been carried out in line with the Massey University Human Research Ethics Committee (HREC) requirements; this committee granted me the required ethics clearance (Ethics Notification - 4000024684). I applied to HEC and obtained the ethics approval before

starting my PhD fieldwork at the Rohingya refugee camps of Bangladesh (Please see the Ethics Committee Approval in Appendix E). I received Massey University Ethics approval in July 2021; however, due to COVID-19 restrictions both in New Zealand and Bangladesh, I could only start my PhD fieldwork in December 2021. Due to this reason, I had to change my plans several times to visit Bangladesh for the fieldwork. When the Covid scenario in Bangladesh, including the Rohingya camps, improved, I could commence and complete my PhD fieldwork in December 2021-January 2022. However, I tried to maintain Covid-19 health protocol, such as wearing masks, washing hands, and maintaining social distance wherever possible. However, maintaining social distance was particularly difficult in certain situations, such as conducting interviews or FGD at the tiny shelters of Rohingya participants.

Some of the key ethical issues are described below, in addition to what I labelled in my article (see 4.3.3).

4.9.1 Procedure to ensure the rights and confidentiality of the participants

There are several ethical issues that have been ensured in this study. These are:

• ***Confidentiality and anonymity:***

During and after field work, several practices were implemented to protect the identity of the participants of this project. For instance, raw data was stored securely on a computer/laptop in a password protected electronic file. The audio records are to be destroyed following six months of the completion of the research project. Participants in this study have been guaranteed complete anonymity. No identifiable information will be released outside. This

study has ensured consent from every participant and addressed matters about confidentiality and anonymity as a priority (Jansen, 2010)

• ***Access to participants and informed consent:***

During the fieldwork, the study procedure was verbally explained to the respondents by the researcher. Inclusion in the study was voluntary. The respondents were provided with an Information Sheet (Appendix D) that clearly mentioned the research objectives, and the intended outcomes. All participants were asked to sign the consent form before the interviews started. If the participants did not know how to sign, then their verbal consent was recorded.

• ***Participants' rights:***

All participants were informed earlier that participation in the study was voluntary and that they could withdraw or leave if they felt uncomfortable answering any questions. Additionally, they were able to stop the interview at any time, decline to answer any questions and withdraw the data up to a week after the interview. An audio-recording device was used during the interviews with each participant's permission. Permission for audio-recording was asked for in the Participant Consent Form, and participants were reminded that the session would be recorded before it started.

It was promised that participants' identity would not be disclosed (Wiles et al., 2006). Keeping the information provided by participants private would be prioritized. Thus, any subjective, confidential, and sensitive information would be treated as a high priority and kept safely away from accessible areas throughout this study. Inherently, no names and addresses would be revealed. Moreover, it was clarified to participants that there would be few incentives to be gained from participating in the study.

• ***Uses of Information:***

The Participant Information Sheet includes a written outline of the research project which specifies the intended use of the results. In terms of this sheet, extensive consideration would be given to whether the research may result in harm for participants. The researcher took specific steps to anonymise the interview transcripts, destroying the audio files after transcription, and using de-identified information in the reports to mitigate this.

4.9.2 Principles and obligations from the Treaty of Waitangi

Relationships: New Zealand, Myanmar and Bangladesh have had a history of colonial oppression. Hence, Māori in New Zealand and Rohingyas of Myanmar (now living in Bangladesh and/or New Zealand) could be viewed through a similar lens of oppression by British colonialism. Again, both the Rohingya refugee communities and Māori are marginalised communities facing inequities (perhaps similar) relating to health. The focus on healthcare experiences of Rohingya refugees can articulate a practical implication of healthcare for Māori communities of New Zealand (Hudson et al., 2010). The Treaty of Waitangi (Te Tiriti o Waitangi) governs the relationship between Māori - the tangata whenua (indigenous people) - and everyone else and ensures the rights of both Māori and Pakeha (non-Māori) are protected. The principles of Te Tiriti o Waitangi – including partnership, good faith, and active protection – are core factors that can be utilised to ensure the rights of the Rohingya refugee communities. I established and maintained consultation with one local Māori expert, Dr. Christine Helen Elers (Ngā Hau), a community-based Māori academic to take advice from her to improve the sensitivity of my research to the Te Tiriti issues.

Purposefulness: This research studied health interventions of marginalised Rohingya refugee communities. I hope that my research findings regarding marginalised Rohingya refugee community will be helpful for the Māori community to explore their healthcare issues. I analysed the healthcare experiences in a way which explored even the colonial and patriarchal influences, which can be beneficial for Māori communities in understanding how healthcare rights or healthcare experiences of their people can be affected by colonial and patriarchal expressions. For my research I utilised the Culture-Centred Approach which is very similar to the Kaupa Māori theory as both theories work by centring the cultural values of a community. The two methodologies are both associated with critical theory and are concerned with uncovering power inequalities that have worked to marginalise communities (Pihama, 1993, 2010). Both the theories seek to decolonise. My research outcomes are effective for understanding ways to create an inclusive society for any group of marginalised people. It can also represent how a marginalised group of people can be treated with respect and dignity in other communities like iwi, hapū, whānau, and Māori.

Critical reflexivity, Cultural humility and Treaty of Waitangi: To conduct this research study I utilised Treaty of Waitangi (Te Tiriti o Waitangi) principles as a framework for critical reflection and cultural humilty. The Te Tiriti principles include the three Ps – partnership, participation and protection of rangatiratanga (Māori authority) (Hamley et al., 2024) that helped me to conduct the interviews of the marginalised refugee community. I always keep in mind the three Ps of Te Tiriti o Waitangi, so that Rohingya peoples' rights may not be hampered by my works at the refugee camps of Bangladesh. Again, while conducting interviews, I always try to build up a culturally appropriate relationship with the Rohingya participants considering cultural humility. Ide and Beddoe (2022) observe that "the

principles of the Treaty of Waitangi underpin the active promotion of cultural safety, valuing cultural differences and considering the other's culture that influences cultural humility" (p. 49). I was equipped to function effectively at the Rohingya refugee camps considering the bi-cultural context (Māori and non-Māori) of the Te Tiriti o Waitangi that helped me to show cultural humility to the Rohingya participants.

Colonialism, Statelessness and Treaty of Waitangi: Though Treaty of Waitangi is known as the founding document of Aotearoa New Zealand, however, by this agreement New Zealand went into colonisation by the British (Gillespie, 2020; Moewaka Barnes & McCreanor, 2019). With the effect of colonisation, the indigenous Māori (Tangata whenua – the people of the land of New Zealand) became landless within their homeland (Howard, 2023). "The significant losses of land, resources and culture experienced by Māori because of colonisation have been carried throughout generations, contributing to cycles of intergenerational trauma and disadvantage for many" (Te Kōmihana Whai Hua o Aotearoa, 2022, p. 1). The history of Rohingya people is also related to colonisation. It is often said that the Rohingya refugee crisis is the effect of colonisation of the British who ruled Myanmar for more than 200 years (between 1824 and 1948) (Anas, 2017; Settles, 2020). To describe colonisation leading to Rohingya crisis, Shahid and Jaffe (2019) explained as, "the British exploited India and Burma's cultural milieu to create differences and executed a strategy of 'divide and rule', sowing the seeds of the perpetual disasters where ethnic groups continue to suffer to date" (p. 1). So, there is a similarity between indigenous Māori and Rohingya refugees as both the communities still struggle to establish their rights lost by colonisation.

4.9.3 Ethical consideration for Bangladesh Rohingya refugee camps

As mentioned earlier, I obtained ethics approval from Massey University, and found out that the Refugee Relief and Repatriation Commissioner (RRRC) office in Cox's Bazar is an appropriate authority that could approve permission to enter the refugee camps and collect data from the Rohingya participants in an appropriate and ethical manner. I obtained a proper permission from RRRC, the Bangladeshi government camp authorities (permission memo no.: 51.04.2200.006.03.346.2021.5292, dated 23.12.2021). In the approval letter, the RRRC mentioned some conditions for ensuring appropriate and ethical data collection, such as an obligation to inform the respective Camp-In-Charge (CIC) before commencing my research work in the camps; a sanction on entering the camps on public holidays in Bangladesh, and an obligation to leave the camps before 3:30 pm on other days (see the RRRC approval letter in Appendix F).

4.10 Trustworthiness of the study

In qualitative research, rigour or trustworthiness is vital for the usefulness and integrity of the study findings (Cope, 2014). Polit and Beck, (2014) observed that trustworthiness or rigour of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study. Lincoln and Guba (1985) suggested that trustworthiness of a study involves establishing:

a) credibility (in preference to internal validity);

b) transferability (in preference to external validity/generalisability);

c) dependability (in preference to reliability);

d) confirmability (in preference to objectivity)

These four characteristics will now be discussed in light of my study:

4.10.1 Credibility

Credibility in qualitative research means that the research process and its findings are believable. Credibility addresses the "fit" between research participants' views and the researcher's representation of the data (Tobin & Begley, 2004). Lincoln and Guba (1985) suggested several techniques to address credibility including prolonged engagement, persistent observation, data collection triangulation, and researcher triangulation. The following provisions, as suggested by Lincoln and Guba (1985), were made to promote the credibility of the current study:

4.10.1 (a) Prolonged engagement

Investing sufficient time to collect data that helps in ensuring in-depth understanding of the phenomenon, is called prolonged engagement (Earnest, 2020). It helps the researcher to draw out true observations and conclusions by spending enough time with the participants. I have had a prolonged engagement with the Rohingya refugee people. I started to work on the Rohingya refugee crisis in August 2017, when I worked as a journalist of Bangladesh Television. In New Zealand, I have worked for a number of years with Rohingya refugees who have resettled in this country. For my PhD fieldwork, I could only spend 22 days in the refugee camp area. However, during this time, I spent all my attention in negotiating, interviewing, and directly observing the Rohingya participants. Thus, the level of my engagement was intense. Altogether, the total length of my engagement work with the Rohingya refugee people is more than 6 years.

4.10.1 (b) Persistent observation

Persistent observation refers to the researcher's capability to identify what is relevant to the study and what is not (Lincoln & Guba 1985). Prolonged engagement and persistent observation are twin strategies that researchers should employ to strengthen credibility. "If prolonged engagement provides scope, persistent observation provides depth" (Lincoln & Guba, 1985, p. 304). I started to engage with the Rohingya people through observation and other activities in August 2017, and this engagement continues until today. I described my participant observation of Rohingya refugees in 4.1.3 section of this thesis.

4.10.1 (c) Data collection triangulation and Researcher triangulation

Triangulation refers to collecting data from multiple sources to get a more complete picture of a phenomenon. When triangulated, data from different sources can be combined and analysed by the researcher to produce a more accurate understanding of the phenomenon being studied. In this study I completed triangulation by employing in-depth interviews, FGD, Participant observation, field note taking, and memoing techniques. These were described in section 4.1 of this thesis.

4.10.2 Transferability

Transferability in qualitative research can be defined as the degree to which the results of a research can apply or transfer beyond the boundary of the project. It is true that findings of a qualitative project are specific to a small number of environments and individuals. So, it may not be possible to demonstrate that the findings and conclusions are applicable to other situations and populations (Shenton, 2004). Lincoln and Guba (1985) suggest that it is the

responsibility of the researcher to provide sufficient information about the research work to enable a new reader to judge the transferability of a qualitative study.

I have given detailed information regarding my research procedure. I have already published three articles titled “Term ‘Rohingya’ accepted worldwide but still taboo in Myanmar” put in 4.2 section, “Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh”, stated in 4.3.3 section and ““Health Means Just to Live” at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention” put in 5.2.1 (a) section of this thesis. In addition, two other articles (already submitted for publication) titled “Living through food rations: A culture-centered study with Rohingya refugees” and ““The beggar’s life is better than us”: A culture-centered study in Rohingya refugee camps” have been put in 5.2.2 (a) and 5.2.3 (a) section respectively of this thesis.

4.10.3 Dependability

Dependability establishes the research study's findings as consistent and repeatable i.e. it ensures the stability of data over time and over conditions. Lincoln and Guba (1985) stress this point by arguing that, practically, credibility ensures dependability through the research design and its implementation. The operational detail of data gathering and addressing the details of the fieldwork proves the dependability of a research study. In this study, these aspects are described in Sections 4.1 to 4.7.

4.10.4 Confirmability

Confirmability of a piece of research occurs once credibility, transferability and dependability of that study have been established (Guba & Lincoln, 1989). Confirmability can be achieved

when the results of a study are verified as being derived from the data as opposed to being shaped by the researcher's biases and assumptions (Tobin & Begley, 2004). In this study, the methodological description in Sections 4.1 to 4.7 sets the research relative to its philosophical commitments and indicates how data emerged through fieldwork. Then the thematic analysis procedure in Section 4.8.3 shows that the research findings are the result of the lived experiences and ideas of the participants, rather than the characteristics and preferences of the researcher, which is a key to assure confirmability.

Chapter 5: Findings

5.1 Introduction

In any refugee camp, "the meaning of health is dynamic because of rapidly shifting circumstances of displacement (Hoffman et al., 2019, p. 3)." In the Rohingya refugee camps of Bangladesh, the meaning of health is indeed dynamic although Rohingyas' displacement does not occur rapidly. The Rohingya refugees have been in a relatively settled position of their life in the 33 camps of Bangladesh since 2017. However, except the recent arrivals since 2017, multiple generations of Rohingyas have been born and have lived their entire lives in the camps (Relief International, 2019). The Rohingyas who came earlier are now living together with the recent arrivals.

The Rohingya refugee community, who are now living in the Cox's Bazar camps of Bangladesh, do not have any opportunity to move. Instead, they have to stay in the camps despite limited access to essential healthcare services. Only some thousands of Rohingyas have been relocated from Cox's Bazar to Bhasan Char, a remote island, by the Bangladeshi authorities since December 2020 (Macdonald et al., 2023). As Bhasan Char is detached from the mainland of Bangladesh and emerged naturally in the sea as a 'floating island' just 20 years ago, the Rohingyas are generally disinterested in relocating from Cox's Bazar to this island (Islam & Siddika, 2022). Whether in Cox's Bazar or Bhasan Char, the social attributes of Rohingya displacement from Myanmar, including their lack of legal status or nationality influence their access to health services and overall health (Tay et al., 2019).

5.2 Overview of themes

The 41 in-depth interviews conducted by me at five refugee camps of Cox's Bazar, Bangladesh generated a vast amount of primary data. After translation and transcription, I had 82,752 words of textual data for analysis. Through the thematic analysis of this huge primary data, I identified the following three themes:

01. Health means just to live.
02. Insufficient food aid
03. Structural barriers to health

Based on these three themes, I have written three articles. The first article describes the meanings of health among Rohingya refugees living in the 33 camps of Bangladesh. The second article demonstrates the insufficient food aid that Rohingyas got through the food rations given by WFP (World Food Programme) and its impact on Rohingya health. The third article outlines the structural barriers to health to Rohingya refugees of Bangladesh. The first article titled ""Health Means Just to Live" at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention" has been published by the Global Journal of Addiction & Rehabilitation Medicine. The second article titled "Living through food rations: A culture-centered study with Rohingya refugees" has been submitted to International Journal of Communication. The third article titled ""The beggar's life is better than us": A culture-centered study in Rohingya refugee camps" has also been submitted to the Journal of International & Intercultural Communication..

5.2.1 Health means just to live

The Rohingya refugees living in the 33 camps of Bangladesh are unable to articulate the true meaning of health. When asked what health meant to them, most participants could not respond to it in a coherent manner. However, articulations on the meaning of health have changed over their six years of stay in the camps. During the author's first visit in July 2018, the Rohingyas observed that fleeing from Myanmar to save their lives was the whole meaning of life and health to them. Fleeing from Myanmar at that time was not easy as the Myanmar security forces fired on the Rohingyas fleeing from their villages to cross the Bangladesh border (Beech, 2017). When the author visited the Rohingya camps in February 2020, they mentioned that getting food rations meant health to them. Lastly, in December 2021-January 2022 when the author conducted his fieldwork at the Rohingya camps, the Rohingyas observed that, to them, health meant freedom from diseases, and proper food assistance.

Living in the camps for decades, the meaning of health to Rohingyas is "just to live" or "just to survive" (Rahman, 2023a). In Bangladesh, for the majority of Rohingyas who came in or after 2017, the meaning of health remains as living hand-to-mouth. With nothing positive to look forward to in the future, health or life to them, is fleeing from the restricted camps, and undertaking boat journeys to reach another country, risking their lives at sea. In 2022, the highest number of Rohingyas – around 3,500 – boarded boats compared with 700 the year before (Ahmed, 2023). For the Rohingya individuals who can risk their lives on a sea voyage in leaky boats, health is just nothing, or an escape from restrictions. One frustrated Rohingya articulated it succinctly: "In the refugee life, health is also a refugee."

Link Three

A part of chapter 5 [5.2.1 (a)] titled, ““Health Means Just to Live” at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention has been published by the Global Journal of Addiction & Rehabilitation Medicine.

I begin this article by exploring the meanings of health to Rohingya refugees and then introduce the CCA and its steadfast commitment to co-creating construction of health at the “margins of the margins.” This article provides the groundwork for the meanings of health among Rohingyas living at the refugee camps of Cox’s Bazar, Bangladesh. Interviews with 53 participants (41 during PhD fieldwork and 12 during pilot study) drive the co-constructed meanings of Rohingya health and wellbeing, pointing to access and connection to harassment in Myanmar, getting shelter in Bangladesh, inadequate food rations and limited healthcare facilities. The Rohingya health meanings have been observed through the intersecting relationship among the three triads (culture, structure and agency) of CCA.

This article describes the overall meanings of health to the Rohingya refugees. The concept of Rohingya health and wellbeing is contrasted with top–down health communication strategies followed at the refugee camps of Bangladesh. Underpinned by CCA, many Rohingya refugees stated that health meant just to live in this world that describes their long struggle and marginality in Myanmar and also living at the margins in Bangladesh camps only by food rations with no means of livelihood. Both of my supervisors, Professor Mohan Dutta and Dr. Akhteruz Zaman, provided feedback on the draft of the article.

5.2.1 (a) "Health Means Just to Live" at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention

(A published article)

Rahman, M. M. (2023). "Health Means Just to Live" at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention. *Global Journal of Addiction & Rehabilitation Medicine, 7(*2): 555710. https://doi.org/10.19080/GJARM.2023.07.555710.

Abstract

Rohingyas are considered the most persecuted refugee community of the world. The Rohingya refugee crisis has been shaped by more than four decades of organised hate, state-led persecutions, and violence with the active production of statelessness. The exodus of Rohingyas from the Rakhine state of Myanmar towards neighbouring Bangladesh started in 1977, just six years after Bangladesh's independence. With the latest exodus in 2017, more than 1.6 million Rohingyas are currently living in Bangladesh. Among them around one million Rohingyas are sheltered in 33 congested refugee camps of Cox's Bazar, a South-Eastern district of Bangladesh. Drawing on the Culture-Centred Approach (CCA), this ethnographic article explores the meanings of health among the Rohingya refugees living in various camps of Cox's Bazar, Bangladesh. This manuscript reports on 53 in-depth interviews of the Rohingyas living in the camps, and also includes participant observations, and a systematic analysis of the literature (both published and grey). In this essay, we argue that living through the aid assistance from the international agencies, the meanings of health to the Rohingya refugees is 'just to live, without any hope.'

Key words: Health, Rohingya, Refugee, Refugee camp, Refugee health

Introduction

The Rohingyas are an ethnic minority Muslim group, who have lived for centuries in the Rakhine state of Myanmar [1]. One of the South-East Asian states, Myanmar (previously called Burma) got its independence in 1948 from the British [2]. It is the largest country in Mainland Southeast Asia, with a total population of 54 million [3,4]. Before the latest exodus of Rohingyas in 2017, the majority of Rohingya people, estimated one million, lived in Rakhine State [5]. Now only an estimated 600,000 Rohingyas remain in Myanmar – including more than 140,000 living in IDP camps [6]. Historians believe Rohingyas lived in the Independent Kingdom of Arakan, now known as Rakhine state of Myanmar, since the 7th or 8th century [7,8]. It is believed that Rohingyas came in contact with the religion of Islam through the Arab and Persian traders [9]. Some researchers observed that the term 'Rohingya' came from the Arabic word 'Raham' meaning sympathy [10].

Following the independence of Myanmar, the Rohingya people have had some sort of citizenship rights but when the Army came into power in 1962, the Rohingyas' generation-long misery started [11]. The military junta suspended the 1947 constitution on which the new country (Burma) was born and introduced a new one in 1974 [8]. Based on the 1974 constitution, the military authorities disqualified many Rohingyas as Burmese citizens [12,13]. The military authorities then enacted the 1982 Citizenship Act, which completely denied the Rohingyas' citizenship rights and made them foreigners in Myanmar [14-16]. The 1982 Citizenship Act also divided the population of Myanmar into 135 ethnic groups, however, Rohingyas were not included in any official ethnicity of Myanmar [17,18]. As a result, since 1982, losing the nationality or identity, the Rohingya communities have been living in Myanmar in denial of the "right to have rights" [19,20].

A chronology of Rohingya statelessness is given below:

1948 : Full citizenship of Rohingyas with National Registration Certificates (NRCs)

1962 : Since November 5, 1962, no NRCs were issued to Rohingyas

1974 : Foreign Registration Cards (FRCs) were given designating Rohingyas as non-nationals under the Emergency Immigration Act

1982 : Rohingyas became stateless with the enactment of the Citizenship Act. Three categories of citizens: full citizens, associate citizens, and naturalized citizens were introduced based on 135 recognized races.

1982 to today: Rohingyas are stateless without any legal citizenship document.

Source: Own data file compiled from multiple sources [21-23]

In 1962, when the Myanmar military came to power, Rohingyas started to lose their various rights in Myanmar [24]. After coming to power, the Myanmar military made the lives of Rohingyas difficult in Myanmar and with the enactment of Citizenship Act 1982, Rohingyas became totally stateless within their state [25]. It is now more than 40 years, Rohingya community does not have any legal document of citizenship. As a result, Rohingyas are now the largest stateless community of the world [26,27]. Since the 1970s to today, facing the discriminatory policies of Myanmar's government and decades long abuse and persecutions, hundreds of thousands of Rohingyas continue to flee their homes [28]. Fleeing from their motherland by state-sponsored targeted persecutions, Rohingyas have sought refuge in neighbouring countries such as Bangladesh, Malaysia, Cambodia, Thailand and India [29,30,5,31]. The total Rohingya population worldwide is now estimated at over 3.5 million and the majority of them are totally stateless and do not have any legal identity document, even refugee status [32,33].

Though Rohingyas became stateless in 1982, their exodus towards Bangladesh started in 1977. At that time, Myanmar Army launched a national drive to register citizens, considering Rohingyas as illegal citizens that drove more than 250,000 Rohingyas into Bangladesh [34,35]. In 1982 becoming stateless, the Rohingyas lost all sorts of human rights in Myanmar that compelled them into forced migration or forced displacement [36,37]. With denied citizenship rights, Rohingyas were subject to government-sponsored discrimination, detention, violence, torture, mass rapes, that causing several waves of mass exodus towards Bangladesh [38,39]. In the refugee camps of Bangladesh, although the Rohingyas are not afraid of losing their lives as was the situation in Myanmar, they are living in desperate unhealthy conditions in overcrowded, makeshift camps [41].

In September 2017, a Washington Post Journalist mentioned that "more than 140,000 Rohingya Muslims have fled violence in Burma over the past 10 days, carrying with them whatever they can on the perilous journey to Bangladesh and arriving hungry, injured and afraid" [42]. The 2017 exodus is the largest exodus, with more than 90 percent of Rohingyas having been forced to flee their homeland and it was the largest human exodus in Asia since the Vietnam War [43,44]. As a result of several exoduses towards Bangladesh including the largest 2017 one, now there are more than 1.6 million Rohingyas staying in this country [45-47]. Among them around one million Rohingyas are being sheltered in various camps of Cox's Bazar since 2017, designated by the Government of Bangladesh as FDMN (Forcibly Displaced Myanmar Nationals) [48,49]. The rest of the Rohingyas are distributed throughout the country, and some are already integrated [50]. In the refugee camps of Bangladesh, although the Rohingyas are not afraid of losing their lives as was the situation in Myanmar, they are living in desperately unhealthy conditions in overcrowded, makeshift camps [51].

Literature review

With no citizenship rights in Myanmar, the Rohingyas are denied owning property, marrying and moving freely in Myanmar today [52,53]. “For the Rohingya, this sweeping and selective denial of rights has resulted in abysmal health outcomes” [54]. Rohingya births are typically unregistered in Myanmar, and the kids do not have any access to essential childhood vaccinations [55]. In Myanmar, more than 80% of Rohingyas predominantly relied on traditional village doctors, paramedics or pharmacy shopkeepers for their medical care [56]. Acute malnutrition, child mortality, and maternal mortality are higher for Rohingyas when they were in Myanmar [57]. In 2009, an FAO survey found that 60% of Rohingya children under 5 years old were moderately underweight and that 27% were severely underweight [58]. In Myanmar, since 1982 to today, Rohingyas are deprived of basic rights such as access to health services, education and employment. The illiteracy rate among the Rohingyas is very high, a staggering 80% of Rohingyas are illiterate [59,60].

Following the recent arrival of Rohingyas in 2017 in Bangladesh, around 150 national and international agencies have responded to ensure the basic health needs of the displaced Rohingyas [48,61]. As of August 2023, there are 954,707 Rohingya refugees living in 33 Rohingya makeshift camps of Cox’s Bazar [62]. The health professional’s ratio working for the Rohingya refugees are approximately 3.07 physicians and two nurses per 10,000 Rohingyas [62] which is lower than the national average of 5.26 physicians per 10,000 Bangladeshis [63]. The health sector of Rohingya camps comprises 36 primary health care centres (PHCs), 140 Health Posts (HPs), nine sexual and reproductive health centres, and 25 other specialized care centres which may vary from time to time [62]. Besides, there are five field hospitals run by non-governmental organizations (NGOs) and foreign governments with a total of 340 hospital beds (5.7 beds per 10,000 population) and up to 630 hospital beds

when needed (10.5 per 10,000 population) [64]. However, still Rohingyas living in the Bangladesh camps are struggling with various health challenges like crowded and unhygienic living conditions, limited WASH (water, sanitation, and hygiene) facilities, scarcity of safe drinking water, and no hope for a better future.

CCA to Refugee Health

The Culture-Centred Approach (CCA) is a health communication framework that works for the marginalized community of the world by engaging the community to find out the relevant solutions of the problems they faced [65]. The Rohingya refugee community is the true example of the marginalized community as they are living for decades without citizenship rights. The CCA works through culture, structure and agency where culture always interacts with structures to form the very basis of agency [66]. In CCA, cultural contexts are the entry points of theoretical insights to describe any community-led solutions experienced by marginalized community like the Rohingya refugee community [67]. Dialogue between researchers and participants appears as the emerging tool in CCA where lived experiences of the participants are used to find out the community-led solutions [66]. CCA seeks to reverse the erasures of marginalized community by narrating lived experiences shared through co-constructive dialogues between researchers and participants [69]. CCA believes listening as the entry points to addressing the needs of a marginalized community like the Rohingya refugees [70]. By listening the voice of the marginalized people like the Rohingya refugees, their problems could be articulated that helps in identifying community driven solutions [66].

Data collection and analysis

The required information of this article has been collected from both primary and secondary sources. Primary information was gained by the author through a qualitative field study

conducted in Rohingya Refugee Camps of Cox's Bazar, Bangladesh, in December 2021-January 2022 through which 41 in-depth interviews of Rohingya people and some focus group discussions took place. Besides, the author visited Rohingya refugee camps in February 2020 and collected 12 in-depth interviews of the Rohingya refugees living there. The author also visited and talked to the Rohingya refugees as a journalist to cover the Rohingya camp visit programme of UN Secretary General Antonio Guterres in July 2018. Since 2017 the author has been working with the Rohingya refugee crisis first while working as a Journalist of the Bangladesh Television from August 2017 to February 2020. Then from March 2020 to today, he has been engaging with the Rohingya refugee people living in New Zealand while working as a Research Assistant of CARE (Centre for Culture-Centred Approach to Research and Evaluation), Massey University.

In two field visits at the Rohingya refugee camps of Cox's Bazar, Bangladesh, the author conducted 53 face to face individual interviews of the Rohingyas. Each interview lasted between 30 minutes and 90 minutes. All the interviews were audio recorded with the consent of the Rohingya participants. Then the interviews have been translated and transcribed by the author to get the texts. Then the textual data has been analysed using co-constructivist grounded theory [71]. This involves an iterative process of going back and forth through the data, engaging in the reflective process of memo writing, field notes observation and cross-checking to find out the codes. The texts of the interviews were coded line-by-line to identify concepts before forming relationships between the concepts, and then providing themes for theoretical integration.

Findings

Rohingya participants indicated that they were apathetic about their health as they were constantly wary about their basic needs after fleeing to Bangladesh. The meanings of health to them is just to live, take shelter, move freely and leading a life without fear. Rohingya refugees living in the camps do not have any proper idea about their health or healthcare. When asked about their health needs or the availability of healthcare facilities in the camps, they could not articulate their responses coherently. When asked about the main diseases they suffered, the Rohingyas replied that they did not know. Rather they answered, “we only would like to live saving our lives.”

Our in-depth analysis identified five predominant themes: (1) Health is just living, (2) Health is just taking shelter, (3) Health means living without any harassment, (4) Health means managing foods for living (5) Health means living without any disease.

Health is just living

During the in-depth interviews, the Rohingya refugees living in the Bangladeshi camps answered that health meant to them just to live with freedom because they had lived for generations in Myanmar without any freedom. Although the Rohingyas are not allowed to leave the camps of Bangladesh, they still feel far better compared to their life in Myanmar. A Rohingya male, who came to Bangladesh in 1991, observed that at the time he came here, health meant just saving his life. However, now health means to him living with no disease. He mentioned:

> I came to Bangladesh in 1991. Though I am not a registered refugee, but Bangladesh Govt. gave me shelter to live with security and provided me shelter. When I came in 1991 at that time health meant to me is just to live. But now health means to me

> proper living with no disease, with proper healthcare facilities. [Rohingya male, 60 years old]

After staying for more than five years in the Rohingya camps of Bangladesh, a Rohingya woman observed that she still felt health was just living. However, she also observed that health meant to her living without any disease. She mentioned:

> I think health means just living. As we are in a position that we do not find any job to live rather to live only on food ration and so health means to me just living by taking food. Again, health means living peacefully without any disease though it is not possible here in the camps. [21-year-old Rohingya female, born in Bangladesh camps]

Health is just taking shelter

Rohingya respondents gave the testimonies of massacres of villagers, burning of homes, sexual violence, and attacks on relatives which are still prominent in their lives and put pressure on their mental health. They mentioned that 4-20 days were needed during their precarious journey to come to Bangladesh, and they could not take any belongings with them during their flight. All of them stated that they could manage to flee from their motherland only with the clothes they were wearing.

Rohingya refugees living in the camps of Cox's Bazar, Bangladesh, expressed their gratitude to the Bangladeshi government for giving them shelter. They said that had the Bangladeshi government not opened the border in 2017, they would have had no alternative to dying in the hands of the Myanmar Army. They said although their living conditions are not good in the camps, they could manage to get shelter and save their lives with the generosity of Bangladesh and its people. A Rohingya male who fled in 2017 observed that.

> We came from Myanmar and the Bangladeshi government had helped us a lot. Had the Bangladeshi government not extended their cooperation, we could not enter Bangladesh. The Bangladeshi government have saved our lives. If Bangladesh did not open its border, if Bangladeshi Muslims did not support us, then we could not reach Bangladesh and did not get shelter. At that time, getting shelter was our priority and meant everything for our lives and health. [Rohingya male, 42 years old]

Another Rohingya male observed, by getting shelter, their lives had been saved. He mentioned to the author as:

> Health means to me is just living through getting shelter. Because our lives were in threat in Myanmar. We fled from our motherland just with a cloth to save our lives. Alhamdulillah we are now in good and peaceful condition in Bangladesh and getting shelter here, our lives are saved. Still, we have had some concerns for our future. [Rohingya male, 29 years old]

Among the Muslim Rohingya refugees, around 500 Hindu Rohingya refugees live in the Cox's Bazar camps. Their living area is separated from other camps. The author had the opportunity to visit the “Hindu Para” (Hindu neighbourhood) and talk with the Hindu Rohingya refugees. A Hindu Rohingya was frustrated to live in the same place for the last five years. He observed that:

> Now the Hindu Para (Hindu camp) is also gheraoed by the wired fencing. Every year the population increases but no extra space is given to us. We are bound to live within this area. Only filling one’s belly is not enough for anyone’s life or health. No recreation facility is present here, but we are just living somehow. In the case of health, it is just refugee life without any hope. [Hindu Rohingya male, 37 years old]

Health means living without any harassment

In Myanmar, the experience of harassment or abuse was very common for the Rohingyas. So, some of the Rohingyas living in Bangladesh camps believe that health means to them living without any abuse or harassment. One elderly Rohingya observed:

> The aid workers provide us with food. We are living here peacefully with a healthy life. It is a much better place than the place where we lived in Myanmar. Because nobody intentionally harassed us here in the camps. In Myanmar at every step, we were harassed by the Myanmar Authority, local Buddhist people. So, living without any harassment means health to me. [Rohingya male, 60 years old]

Many Rohingya individuals lost their relatives during the 2017 violence against them. According to a report by the Ontario International Development Agency (OIDA), nearly 24,000 Rohingyas had been killed by the Myanmar security forces in 2017 [68]. As a result, the meaning of health to those who survived the genocide is just to subsist. A Rohingya male stated:

> My relatives have been killed by the Myanmar Army. When we started to leave our homes, they also continued to burn our houses. The Rohingyas were also killed when they started to cross the border. They (Army) tortured and raped our mother-sisters, killed our brother-sisters. They also threw our children in the water and opened fire to kill them. Here in Bangladesh, we get shelter and could save our lives. Fleeing from Myanmar and living here in Bangladesh means everything or means health to us as no one harasses us here. [Rohingya Male, 42 years old]

Health means managing food for living

All the Rohingya participants commented that they spent their time idle in the camps as they are not permitted to do any job outside of the camps. The Rohingya refugees confirmed that they did not have any job and were totally dependent on the relief aid provided by the local and international agencies. A few Rohingyas mentioned that they could manage some work inside the camps offered by NGOs or international donors which sometimes helped them to earn a little.

The Rohingya refugees are too busy to manage food and clothes for their living in the camps. Thus, when the author talked about health, they replied that they did not have any idea how they could manage good health as their main concern was to manage food for survival. One of the Rohingya refugees replied, "we are busy with our living needs, not with our health." A Rohingya male observed:

> We are getting food ration from WFP (World Food Program) and the small family of 4-5 members are managing more or less well but the larger family with 6-7 members are facing difficulties with the ration given by the aid organizations. No, we generally do not do any work here in the camps and we do not have the permission to go outside of the camps. Some work may be done by us inside the camps offered by the NGO, school etc. [Rohingya male, 39 years old]

A Rohingya male, who has been living in a camp for the last five years, observed that they are totally dependent on food ration, although that is not enough for their living. He observed that they would die if food ration will be stopped. So, health means to him managing to get hold of food in order to live. He observed:

> Food ration is not enough for our living. But that is only the source of our living. We do not have any opportunity for work, camps are gheraoed by wired fencing and no

opportunity to go outside. If we do not get the food ration, then we all will die without taking any food. So, to me, health is managing food in the overcrowded camps. [Rohingya male, 38 years old]

Health means living without any disease

The Rohingya refugees who stayed in the Rohingya camps for years, observe that health means to them living without any disease. Before fleeing to Bangladesh, the Rohingyas could not find any health professional for the treatment of the disease [72]. In the camps of Bangladesh, though there is a scarcity of medical professionals, the Rohingyas have some alternatives, such as visiting the field hospitals or even pay a visit outside of the camps for better treatment. So, they could now think, health means living without any disease. One Rohingya female who was born in the refugee camps of Bangladesh stated:

> I think health means living without any disease. When a person can live with an appropriate supply of food, healthcare needs, recreation facilities then his/her health becomes normal. But we get the same items of food, poor healthcare facilities and no recreation activity and so our health is not in good condition. Again, living in a refugee life, anybody's health will deteriorate automatically, I believe. [23-year-old Rohingya female, born in Bangladesh camps]

Another Rohingya female who came to Bangladesh in 2017, observed that she also believes, health means freeness from any disease. However, she observed that it is very difficult to become free of disease in the camps because of the poor drainage system and congested living conditions. She mentioned:

> I think health means living without the attack of any disease. But here in this shelter it is difficult to manage our health. We are frequently attacked by diseases. And I think

> the bad smell of latrines and poor drainage systems are adversely affecting our health, but there is no alternative. [Rohingya female, 25 years old]

Discussions

The overall health and hygiene situation in the Rohingya camps is still poor. Significant public health risks of Rohingya refugees are due because of the overcrowded living conditions and poor water, sanitation, and hygiene (WASH) practices at the camps [73]. The Bangladesh Government along with its development partners have tried to provide basic services such as shelter, food, water, sanitation, access to healthcare to meet the basic needs of such a huge population of Rohingya refugees [73,74]. However, despite significant progress, till today the Rohingya refugees struggle to live in the overcrowded refugee camps of Bangladesh [51]. One of the Rohingya males observed, "it is the life of a Musafir (stranger). We get the aid from the Govt. of Bangladesh/International agencies. What we need we get 50% of our requirement and by this 50% we somehow lead our lives in the camps."

It is very difficult for Rohingyas to maintain their health as they are living in congested camps with 40,000 people per square kilometre [75,76]. The poor health conditions were exacerbated by the COVID-19 pandemic period as the refugees were always in fear of the disease and did not have enough protective measures [77]. There have been consistent efforts towards improving health facilities by the agencies, capacity building of medical personnel; and preparation to combat disease outbreaks at the Rohingya camps. However, this effort has not been reflected in the Rohingya articulations presented here. The respondents said that they always faced shortage of healthcare facilities at the camps. One Rohingya participant said: "The health facilities are not enough in the camp area. We need more healthcare

facilities. In the camps, there are no treatment facilities for serious diseases like diabetes, blood pressure etc."

During the Rohingya camp visits, the author noticed that there was hardly any window in the small houses/shelters of the Rohingya families. The smoke oozing out of cooking activities inside the houses and other burning activities in the camp explains why the Rohingya refugees are prone to respiratory diseases. It was also found that sanitation was a major problem for the Rohingya refugees living in the camps. A single toilet (latrine) was used by 7-10 families or over 40 individuals. There was no gender segregation for the toilets that made life even harder especially for the girls and women. Due to space shortage in the camps, latrines were often built near one another and too close to shelters and water supplies. A Rohingya female observed, "there is no dedicated latrine for the females. The same latrine is used by both males and females. Moreover, foul smell from the latrine often comes out that creates problems and affects our health."

Considering the overall scenario of the refugee camps, it may be stated that the Rohingyas are living with limited healthcare facilities. Their health is totally dependent on aid supply as they do not have any opportunity of work and not allowed to go outside of the camps. It is clear that the decisions regarding their health had been made without an active participation of Rohingyas living in the camps. They are the passive users of the decisions made by the local and international agencies. However, the Rohingyas do not have any clear idea about their health. They maintained that they could do nothing to maintain their health and wellbeing as they do not have any source of income. A Rohingya youth (25 years old) observed, "We are just living within the camps. We cannot go outside of the camps as per the directions of the Bangladeshi government. There is no or little job opportunity inside the

camps. As a result, more than 98% of Rohingyas are now jobless and wasting time without doing anything."

Conclusion

The Bangladeshi authorities still treat the Rohingya crisis as a short-term challenge, focusing on repatriation and refusing to engage in any multi-year planning for the Rohingya refugees [78-80]. As a result, long term context-specific strategies and a multi-stakeholder approach could not be taken to address the health problems or overall wellbeing of the Rohingya refugees living in Bangladesh. It is also important to understand the knowledge, attitude, and views or voices of the Rohingya population regarding different health events, and their culture, beliefs, and norms of health seeking behaviour, to increase the effectiveness of health care services at the camps [81]. A Rohingya male, who has been staying in the camps since 2017, observed, "we can only learn about any decisions made about us. No NGO, government or international agencies call us or discuss with us. Rather, they make decisions on their own."

The Governments of Bangladesh and Myanmar and UN agencies—all have made official statements that the ideal solution to the Rohingya refugee crisis lies in the repatriation of Rohingyas to Myanmar. However, none of the three repatriation agreements that have been signed between Bangladesh, Myanmar and UN agencies formally include the Rohingya refugees or even mention the name 'Rohingya' [82]. Any decision-making process about Rohingyas, whether with respect to services like health, relocation or repatriation fails to include the Rohingya representation [83]. Now it is only prudent that, Bangladesh and all its development partners must let the Rohingya speak for themselves for their rights [83]. Amnesty International in its 2020 report "Let us speak for our rights," highlights the voice of

Rohingya refugees about their access to health care [84]. Culture Centred Approach (CCA) also believes that without having a voice, no solution for health can be fulfilled by the 'margins of the margins' Rohingya refugee community [85].

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5.2.2 Insufficient food aid

As the Rohingyas are not allowed to go outside of the camps or engage in any formal work, the food aid they receive from the World Food Programme (WFP) is their only source of sustenance (UNHCR, 2023a). Although the Rohingyas had started to come to Bangladesh in 1977, WFP started to provide food assistance to them in 1992 (WFP, 2006). The WFP started its operation in Bangladesh in 1974 to support the people in coping with the impact of natural disasters, such as cyclones and floods (WFP, 2023b). During the 1977-78 first Rohingya exodus, food assistance to the Rohingyas was provided by the Bangladeshi government with support from UN organisations. At that time, food rations were distributed to each Rohingya household on a weekly basis by the camp administration with the help of the majhis or Rohingya community leaders (Crisp, 2018; Lindquist, 1979). However, there was an allegation that, in 1978, the Bangladeshi government used food aid as a political weapon to incentivise the return of the Rohingyas from Bangladesh to Myanmar (Dock, 2020).

From 1994 to 2017, WFP provided food rations only to the registered Rohingya refugees of Bangladesh. Up to 1992, the government of Bangladesh gave refugee status to the Rohingyas seeking refuge. After the latest exodus of Rohingyas in 2017, there were only 33,519 Rohingyas living in the camps as “refugees,” and the rest living there were registered as “FDMN” (Faiz et al., 2022). However, after 2017, WFP provided food ration to all (labelled as refugee or FDMN) Rohingyas living in the camps. From 2017 to the beginning of 2023, each Rohingya received a monthly food ration of $12. However, from March 2023, Rohingya refugees saw their rations cut to $10 per head, which was even further reduced to just $8 in October. This significant reduction means each Rohingya currently receives food aid worth 27 cents a day, which negatively affects their overall health.

Link Four

A part of chapter 5 [5.2.2 (a)] titled, “Living through food rations: A culture-centered study with Rohingya refugees” has been submitted to the International Journal of Communication.

This article has been written on the basis of my research study findings at the Rohingya refugee camps of Bangladesh. It describes the scarcity of food aid as the Rohingyas are totally dependent on it without any options. This article provides the scenario of food scarcity of Rohingya refugees that is a direct contributor to poor health and works to inhibit agency in the pursuit of their health and well-being. Based on the Culture-Centred guided in-depth interviews with 41 participants, this article identifies three key themes: inadequate access to food, monotonous and culturally inappropriate food, and resorting to selling food. Having been confined in the camps with no access to any job, Rohingyas are totally dependent on food ration for their sustenance in the camps that affect their overall health. Both of my supervisors, Professor Mohan Dutta and Dr. Akhteruz Zaman, provided feedback on the draft of the article.

5.2.2 (a) Living through food rations: A culture-centered study with Rohingya refugees

(A submitted article)

Rahman, M. M., Dutta, M. J. & Elers, P. (2023) (Submitted). Living through food rations: A culture-centered study with Rohingya refugees. ***International Journal of Communication*****.**

Abstract

The Rohingya people, an Indo-Aryan Muslim ethnic group from Myanmar, have faced decades of discrimination and repression, rendering them the world's largest stateless community. Grounded in the culture-centered approach, a critical methodology that positions culture, structure, and agency in dialectical relationships, this study explores the issue of food scarcity among Rohingya people residing in refugee camps in Cox's Bazar, Bangladesh. Drawing from ethnographic research and 41 in-depth interviews with Rohingya refugees within these camps, 3 key themes were identified: Inadequate access to food, monotonous and culturally inappropriate food, and resorting to selling food. These findings depict how food scarcity is a direct contributor to poor health and works to inhibit agency in the pursuit of health and well-being in the refugee camps, informing a discussion about the interplay of communicative and material inequalities.

Keywords: Rohingya refugees; communication and food insecurity; culture-centered approach; refugee health

Introduction

In recent years, there has been a growing recognition of the interconnection between communication and food scarcity (Schraedley et al., 2020). Emerging culture-centered work has examined cultural practices of food and how meanings of health can manifest in the deprivation of food (e.g., Dutta, Anaele, & Jones, 2013; Dutta, Hingson, Anaele, Sen, & Jones, 2016; Koenig, Dutta, Kandula, & Palaniappan, 2012; Tan, Kaur-Gill, Dutta, & Venkataraman, 2017) when set against the discursive erasure of food insecurity (and those experiencing it). Despite this growing awareness, dominant communication research often overlooks the experiences of displaced communities, such as refugees situated in the global margins. This is exemplified by the Rohingya refugees who escaped state-sponsored violence in Myanmar, only to find themselves confined to overcrowded camps in Cox's Bazar, Bangladesh (Ali & Duggal, 2022). Prevented from seeking formal employment, these refugees are entirely dependent on food rations provided by humanitarian organizations like the World Food Programme (Hero, 2023). Being physically present in Rohingya refugee camps in Cox's Bazar, the first author observed the impacts of recent food rationing cuts and the absence of effective communication channels regarding these circumstances, bearing witness to a humanitarian crisis.

The present study explores the prevailing issue of food scarcity within five refugee camps in Bangladesh, drawing from ethnographic research and 41 in-depth interviews with Rohingya refugees. In the next section, we outline the key tenets of the study's methodological grounding, Dutta's (2008, 2018) culture-centered approach (CCA), a critical methodology that positions culture, structure, and agency in dialectical relationships that play out in the realm of food options and practices (de Souza, 2023; Elers, Te Tau, Elers, Jayan, & Dutta, 2021). Subsequently, we provide a backdrop of the Rohingya refugees in focus, discussing their persecution and exodus from Myanmar, as well as the distribution of food

rations in the Rohingya refugee camps in Cox's Bazar. Following an overview of the methods, we present the findings, which elucidate how food scarcity contributes to poor health outcomes while simultaneously constraining agency in the pursuit of health and well-being. The inaccessibility of culturally significant foods also suppresses traditional food practices. Our study advances the understanding of health as fundamentally intertwined with food inaccessibility within the camps, informing a discussion about the interplay of communicative and material inequalities as an entry point for the development of strategies for improving access to essential food supplies.

The Culture Centered Approach

Dutta's (2008, 2018) CCA is a critical health communication framework that works with communities situated in the "margins of the margins"—those erased in dominant discursive spaces. The Rohingya people, who have endured decades of discrimination and repression and are the world's largest stateless community (Ali & Duggal, 2022), epitomize the margins of the margins. Central to the CCA is the concept of communication inequality, traditionally associated with unequal access to health information. However, within the CCA, this concept also encompasses the unequal communicative infrastructures to express voice and respond to information dissemination (Dutta, 2021). The inclusion of this second dynamic in the CCA recognizes the need to address voice inequalities as a critical factor in rectifying health disparities (Rahman & Dutta, 2023). Thus, the construct of communication inequality within the CCA recognizes community agency and the pivotal role of communication structures in fostering equitable health outcomes, with the development of communication infrastructures involving dialogic, two-way participatory processes.

The key tenets of the CCA are culture, structure, and agency, all of which are intricately involved in food practices. Culture involves the everyday construction of shared meanings. Cultural food prohibitions can serve as a form of expression between the body and

the supernatural, with certain religions influencing dietary practices through diverse rules, symbols, and meanings (Monterrosa, Frongillo, Drewnowski, de Pee, & Vandevijvere, 2020). Structure refers to the distribution of resources, with communities situated in the margins of the margins often facing structural obstacles in accessing food, such as financial constraints and the negotiation of conflicting material needs (e.g., Elers et al., 2021; Tan et al., 2017). For instance, CCA research conducted among marginalized women in the United States revealed how they were unable to exercise agency in their preferred foods due to inadequate government support and limited availability of nutritious options in charitable food settings (de Souza, 2023). This highlights an inherent tension within the neoliberal model of health citizenship, which prioritizes individual behavior change while overlooking governmental responsibility in creating healthy food environments. Finally, agency refers to individuals' ability to engage with and navigate these structures, such as dietary choices serving as a means of preserving social identities and expressing cultural affinities (Koenig et al., 2012).

The CCA is committed to understanding the meanings that communities situated in the margins of the margins construct at the intersection of structure, culture, and agency. Yet as Gordon, Hunt, and Dutta (2022) stated, it is insufficient to conceptualize "exploitative and extractive food system relations in abstraction . . . The embodied work of communicative struggle involves the building of voice infrastructures at the margins" (p. 3). The CCA emphasizes the importance of the physical presence of researchers in communities over time and actively listening in, working toward understanding and addressing the needs of those situated in the margins of the margins (Dutta, 2014). Listening works as "a communicative practice that interrogates the hegemony of the existing structures and opens the discursive sites and processes to new imaginations and new possibilities" (Dutta, 2014, p. 73). By listening to the voices of communities situated in the margins of the margins, such as Rohingya refugees, problems can be articulated, assisting in the identification of respective

solutions (Dutta, 2018). In this sense, the CCA offers both a methodological blueprint for working with marginalized communities, commencing with fieldwork comprising ethnography and in-depth interviews, as well as a metatheory for conceptualizing social change.

The Rohingya People: A History of Discrimination and Persecution

The Rohingya Exodus and Resettlement

The Rohingya people, a predominantly Muslim ethnic minority group, have their own language, history, arts, culture, and food habits (Ali, 2021). They have been living in Myanmar for centuries (Htun, Lwin, Naing, & Tun, 2011; Uddin, 2023) and generally reside in Rakhine, one of the poorest states that borders Bangladesh (Poling, 2014). Myanmar gained independence in 1948, but successive governments have denied the existence of the Rohingya people in Myanmar (Selth, 2018). The 1982 Citizenship Law, formulated by the then Myanmar Army government, made Rohingya people illegal residents (Lee, 2019) effectively rendering them stateless (Cheesman, 2015; Chickera, 2021). As illegal residents in their home country, the Rohingya people were not allowed to move freely, had limited or no access to health care, education, and employment (Amnesty International, 2017), and required permission from authorities for marriage and childbirth (Fortify Rights, 2014).

The state-sponsored discrimination, violence, and persecution against the Rohingya people have led to a significant exodus from Myanmar, with hundreds of thousands fleeing to neighboring countries (Faye, 2021; Macdonald, Mekker, & Mooney, 2023). Since the 1970s, the Rohingya people have sought shelter in Bangladesh, often crossing the Naf river to reach Cox's Bazar (Ahmed, 2021; Firoz & Hanif, 2024). The most substantial mass exodus occurred in 2017 following genocidal attempts by the Myanmar Army (Aziz, 2020). Consequently, the Rohingya population in Myanmar has drastically reduced, with the majority now residing outside their homeland. Before 2017, Myanmar was home to more

than 1 million Rohingya people, but today, only 600,000 remain (Human Rights Watch [HRW], 2022).

There is no exact figure regarding the current Rohingya population in Myanmar. It is estimated that around 600,000 Rohingya people are now left in Myanmar, and before the 2017 genocide, an estimated 1.4 million Rohingya people lived in Myanmar (Merlo, 2024; O'Brien & Hoffstaedter, 2020). Again, as of March 31, 2024, the existing number of Rohingya people (official figure) sheltered in Bangladesh is 978,003 (United Nations High Commissioner for Refugees [UNHCR], 2024). The breakdown of the Rohingya population in Bangladesh is shown in Table 1.

Table 1. Breakdown of the Rohingya Population.

Total no. of Rohingya people at 33 camps of Cox's Bazar	942,944
Total no. of Rohingya people at Bhasan Char[19]	35,059
Total	978,003

However, there are thousands of Rohingya people living in Bangladesh, outside of the camps, who have already been integrated into Bangladeshi society; hence, the estimated total population of Rohingya people in Bangladesh is around 1.6 million (Halim, 2021; Rahman, 2023).

Most Rohingya people, around 1 million, now live in 33 refugee camps in Cox's Bazar comprising bamboo and tarpaulin shelters. Although Bangladesh has allowed the Rohingya people to enter its territory, the country does not recognize them as refugees, rather terming them "Forcibly Displaced Myanmar Nationals" (Dempster & Sakib, 2021). In the 1990s, the Bangladesh Army established the "majhi system" in the Rohingya camps to organize humanitarian assistance for the refugees (Assessment Capacities Project [ACAPS],

[19] Bhasan Char is an island that belongs to Bangladesh and located in the Bay of Bengal. It is around 60 km from the mainland. The Bangladesh government has built a rehabilitation project in Bhasan Char, for around 100,000 Rohingya people who were to be shifted from Cox's Bazar. The shipment of Rohingya refugees from Cox's Bazar to Bhasan Char started in December 2020 (Islam & Siddika, 2022).

2018). The majhi (whose literal translation into English means “boat steersman”) is a Rohingya community leader, usually a man, informally selected by camp authorities to support officials in maintaining law and order and act as a focal point for camp management activities (Translators Without Borders [TWB], 2020). The majhi system was abolished in 2007 but reintroduced after the 2017 Rohingya exodus to the refugee camps in Cox’s Bazar. While majhis were established to help act as intermediaries between the Rohingya community and aid organizations in the camps, there are concerns raised that information acquired by the majhis may not be efficiently communicated to the wider Rohingya refugee population (Toma, Chowdhury, Laiju, Gora, & Padamada, 2018).

The Distribution of Food Rations to Rohingya Refugees in Cox’s Bazar

For the approximately 1 million Rohingya people residing in refugee camps in Cox’s Bazar, the primary means of sustenance comes from the assistance provided by international agencies in conjunction with the Bangladesh government (Rahman & Mohajan, 2019). Up until March 2023, the monthly food aid of US$12 per person per month has been extremely insufficient for their sustenance (Peter, 2023). This allows each Rohingya person or family to collect 40 food items from the retail outlets operated by the World Food Programme (WFP) within the refugee camps (Vallas & Sharma, 2021; World Food Programme [WFP], 2023a). These outlets offer Rohingya people some essential staples such as rice, fortified cooking oil, eggs, lentils, and some local fruits and vegetables (ACAPS, 2022).

Since 2017, Rohingya refugees residing in different camps of Cox’s Bazar receive food rationing through two methods: General food distribution (GFD) and electronic food vouchers or “e-vouchers” (Hoddinott, Dorosh, Filipski, Rosenbach, & Tiburcio, 2020). The GFD program was initiated on the arrival of the refugees in 2017 and continued until 2020 (WFP, 2020a). Under the GFD program, food rations, including rice, vegetable oil, and

lentils were distributed among Rohingya households, calculated on an estimate of five members per family (Oh, 2018). However, all Rohingya families, regardless of size, received the same food rations through the GFD program. This approach was introduced to address the initial challenges of gathering household data during the influx in August 2017, often referred to as in-kind assistance (WFP, 2020a). In 2018, the WFP introduced an e-voucher system for newly arrived Rohingya refugees, though the e-voucher system was already in operation among the previous Rohingya refugees since 2014 (WFP, 2018a). The e-voucher functions like a debit card and is issued in the name of a senior Rohingya woman, along with one alternate nominee (Hoddinott et al., 2020; WFP, 2018a). WFP observed that 89% of all principal recipients of e-vouchers were Rohingya women and the rest were men (WFP, 2020b).

Since 2020, the WFP has offered almost all Rohingya refugees in the camps the option to receive e-vouchers for obtaining food items from the WFP outlets. As of January 2023, all Rohingya refugees living in Cox's Bazar received food assistance through e-vouchers (WFP, 2023b). This initiative represents the first establishment of e-voucher outlets by WFP for refugees globally, with Cox's Bazar serving as the pioneering operation (WFP, 2022). Until March 2023, Rohingya refugees could collect around 13 kg of rice, 500 g of chickpeas, 250 g of flour, five eggs, and some other basic cooking supplies per person for a month through the e-voucher (Porter, 2023). The most vulnerable, including the elderly, households headed by children, and households with persons with disabilities, could receive an additional US$3 for purchasing fresh food products, supplementing the basic assistance of US$12 (WFP, 2023c).

Most Rohingya refugees residing in the camps do not have an adequate food supply for their health and well-being (Jubayer et al., 2023; Shohel, 2023). An assessment by the WFP determined that 86% of Rohingya refugees were highly vulnerable to poverty and

hunger in 2020, marking an increase from 70% in the preceding year (UNHCR, 2021). In March 2023, a United Nations organization reported that 45% of Rohingya families did not have a sufficient diet, 40% of Rohingya children suffered from stunted growth, and more than half endured anemia (Office of the High Commissioner for Human Rights [OHCHR], 2023). However, due to funding shortages, in March 2023, WFP reduced the food aid from US$12 to US$10 per Rohingya refugee, and in June 2023, it was further reduced to US$8 (UNHCR, 2023a), meaning that each Rohingya refugee now receives 27 cents a day as their food ration, down from the earlier allocation of 40 cents a day. The new food ration provides them with less than 1,700 Kcal per day (Tafhim, 2023), well below the recommended daily intake. The two successive cuts in food ration in 2023 have raised concerns among Rohingya refugees, who fear it will push them into starvation (Sankar, 2023). Against this backdrop and through the lens of the CCA, this study presents the findings of 41 in-depth interviews with Rohingya refugees, aiming to explore the following research question:

> *RQ1: What are the lived experiences of food and food scarcity among refugees residing in the refugee camps in Cox's Bazar?*

Data collection and analysis

Study procedures for this research were deemed to be low risk through Massey University, New Zealand's ethics procedures, and all participants completed informed consent processes. Before commencing the research, the lead researcher had experience engaging with Rohingya refugees. His engagement dates back to 2017 when he worked as a journalist for Bangladesh Television until moving to New Zealand in 2020, where he continued researching Rohingya refugee communities. The second researcher has been actively involved in researching Rohingya refugee communities in Malaysia, India, and New Zealand since 2018. This study was conducted within five Rohingya refugee camps situated

in Cox's Bazar district in Bangladesh. Approval was sought and granted by the Refugee Relief and Repatriation Commissioner office, which was required to undertake the research with security checkpoints screening all people entering and exiting the camps. Subject to this approval, the researcher had to leave the refugee camps before 3:30 p.m., and no fieldwork could be undertaken on Bangladeshi government holidays.

The lead researcher visited five Rohingya refugee camps during three separate visits to Cox's Bazar: The first in July 2018, the second in February 2020, and the third from December 2021 to January 2022. Spending approximately 6 hours each day within the camps, this researcher undertook ethnographic observations, documented through journaling, and during the final visit, conducted 41 in-depth interviews of resident Rohingya refugees aged 18 years and older. This researcher is Bangladeshi and of Muslim faith, which assisted in fostering shared understandings around Rohingya cultural norms. On the first visit to each camp, the researcher engaged with majhis who supported the participant recruitment. Additionally, a male Rohingya community researcher, proficient in Bengali (spoken by the lead researcher), also facilitated participant recruitment and the interview conduction. A female community researcher could not be recruited, so the researcher took precautionary measures consistent with the cultural and social norms of female participants, including upholding the purdah (a religious and social practice by which a woman is kept out of the view of men they are not related to other than her husband; see Papanek, 1973). The male Rohingya community researcher from the same cultural background and community accompanied them during the research activities, while the lead researcher maintained a respectful distance from this interaction (further discussion about the cultural sensitivities in the study is provided in Rahman, 2022). The demographic information is outlined in Table 2.

Table 2. Participant Demographic Information.

Demographic	Number of Participants (Total = 41)	Proportion of Total (%)
Age, years		
18–34	23	56.1
35–54	9	22.0
55+	9	22.0
Gender		
Male	19	46.3
Female	22	53.7
Time residing in Bangladesh		
0–5 years	0	0
6–10 years	25	61
10+ years	10	24.4
Born in Bangladesh	6	14.6
Refugee camp		
Camp 1	13	31.7
Camp 2	5	12.2
Camp 3	9	22
Camp 4	10	24.4
Camp 5	4	9.7

Each interview, ranging from 30 to 90 minutes in duration, was conducted within the participants' dwellings and recorded with the participants' consent. In keeping with Dutta's (2018) CCA, the interview guide comprised broad questions addressing individual and community challenges to health and well-being, as well as respective solutions going forward. The interviews were then translated (from Bengali to English) by the first researcher. We recognize the inherent limitations of the translation process, which necessitate the interpretation and rearticulation of meanings, but this was the only practical way that we could analyze and present the findings within our research team. To assist in ensuring the validity of the data, the second author (who is also fluent in Bengali) cross-checked and compared the transcribed data.

Initially, the researcher had planned to conduct up to 30 in-depth interviews, but this was extended to 41 interviews to achieve data saturation. The transcripts were analyzed using

co-constructivist grounded theory (Charmaz, 2000) by the first author and then reviewed by the second author; any disagreements were mediated through dialogue. The analysis involved an iterative process of line-by-line analysis of the transcripts, going back and forth through the data, engaging in a reflective process of memo writing, field notes observation, and cross-checking to identify codes. For instance, during open coding, various codes such as "same food items every month," "limited curry items," "daily food is only rice," "purchasing fruit creates a shortage of staple food," and "not able to buy food as per wish" were identified and later grouped under the theme "Monotonous and culturally inappropriate food." Open coding, axial coding, and selective coding led to the identification and refinement of themes within the emerging theoretical framework. Three overarching themes were identified: (1) inadequate access to food, (2) monotonous and culturally inappropriate food, and (3) resorting to selling food.

Findings

Inadequate access to food

The inadequate structural access to food significantly impacted the health and well-being of Rohingya refugees in the camps. The issue of food scarcity in these camps was first identified as far back as 2002 (Médecins Sans Frontières [Doctors Without Borders], 2002), and it has persisted even after the significant exodus of 2017 (Khan, 2018). From the interviews and observations carried out in these settings, it was evident that food scarcity has become an intrinsic part of the daily existence of Rohingya refugees. Participants revealed lived experiences of hardship stemming from a structural dependency on WFP food rations, whereby refugees have no choice but to rely on these organizations due to broader constraints, including employment restrictions. This structural dependency was expressed by a participant who gave the following explanation:

> Food ration is not enough for our living. But that is only the source of our living. We do not have any opportunity for employment, we are gheraoed [surrounded] by wired fencing. And so, if we do not get the food ration then we all will die without getting any food. (P-31, 38-year-old man)

This excerpt depicts how the dependence on WFP food rations stems from the restricted physical environment—materialized and signified in their living conditions being: "gheraoed by wired fencing." This serves as a material structural restrictor to agency in pursuing health and well-being, rendering individuals physically incapable of seeking income opportunities or accessing alternative food sources. Another participant explained that if the food rations ceased, "then we all will die. Because we are now confined in the camp with the fencing, and we do not have any employment opportunity" (P-27, 36-year-old woman).

Moreover, participants described how their food rations have deteriorated since 2017. This decline is likely because Bangladeshi people donated items, such as food and clothing, to the Rohingya refugees in the early stages of the exodus. As a 27-year-old Rohingya man observed,

> When we came in 2017, at that time we got various items of food, fish, etc., but now we do not get enough food. Now we get the fixed items of food. With those fixed items of food, we are just living but that does not fulfill our nutritional needs. Many children in the camp seem malnourished. Not only the children, but we are also facing a shortage of nutrition. (P-18)

This situation reveals how changes in aid distribution can contribute to depriving Rohingya refugees of access to food and essential nutrition, extending health disparities. Public donations met an immediate need within the camps but fell short in establishing long-term structural infrastructures required to sustain Rohingya refugees over time.

Furthermore, while conducting interviews across various camps in Cox's Bazar, the interviewer encountered four participants who did not possess a food ration card (e-voucher). This posed substantial difficulties in their ability to access food from the WFP outlets, leaving them dependent on the assistance of others. A 21-year-old Rohingya woman explained how not possessing a food ration card affected her:

> A great problem for me. After my marriage, I came to this shelter, but still, my name has not been included in the ration card. I have applied but still did not get the card. As a result, there are some problems with my husband. He always criticizes me as my name was not included before my marriage. (P-10)

The above excerpt uncovers administrative and cultural complexities surrounding ration card distribution and its implications on personal relationships within the Rohingya community.

The devastating health impacts resulting from food scarcity were further emphasized by other participants, particularly concerning their children. Participants stated, "My main tension is whether we can live without proper food . . . our children are growing with less nutrition, and they are not properly grown up" (P-21, 30-year-old woman) and "My son's age is one-year, two-months. But I cannot manage his good food. He cries several times for food, but I cannot manage any dry milk . . . The cost of dry milk is very high, I cannot buy that" (P-26, 19-year-old woman). These accounts highlight severe health repercussions resulting from insufficient access to proper nutrition within the camps.

Monotonous and culturally inappropriate food

The structure of food accessibility further constrained the agentic expression of cultural practices relating to food. A 43-year-old man described this as "the life of a musafir" (P-01); in this context, "musafir" loosely translates to "stranger," suggesting a sense of

alienation or disconnection and associated emotional tolls on their well-being. Most participants expressed significant dissatisfaction with the limited variety of food that they receive through the rations, noting that they are unable to choose their meals and usually consume the same type of food every day. Participants stated that they were taking the "same type of food every day. For the last four days I had only rice with potato mash" (P-20, 22-year-old man) and "Today is the consecutive third day we are taking the rice with dal [lentils]" (P-39, 42-year-old man), which was depicted as being "monotonous" (P-14, 23-year-old woman) and "boring" (P-09, 22-year-old woman). Rice has served as the staple food for the Rohingya community, with 97% of the population relying on monthly rice collections from WFP outlets (Talukder et al., 2022).

While residing in Myanmar, the Rohingya people enjoyed the flexibility of complementing their rice with vegetables or fish, in adherence to their traditional diet, known as Sutki-vat, which consists of dried fish and boiled rice (Roy et al., 2022). However, in the camps in Bangladesh, Rohingya refugees are constrained to subsisting primarily on rice and lentils (Hero, 2023), which is inconsistent with their cultural culinary traditions. A 32-year-old Rohingya woman stated,

> Maximum days we generally take rice with dal [lentils] though we Rohingya people do not like dal as the Bengali people like it. But we do not have an alternative, rather we are bound to take the food as we do not have any income in the camp area. (P-33)

Food is not only a means of nutrition; it also holds cultural significance. Among the Rohingya people, fish is culturally important, yet it is largely absent in the Bangladesh camps (Khan, 2018). Interviews with Rohingya refugees confirmed their preference for fish and its general unavailability in the camps, demonstrating a disconnection between their cultural

food preferences and the provided rations. As a 30-year-old man expressed, “We cannot eat food as per our wish. It is now our life!!” (P-07). Another participant questioned, “Without a good torkari (curry) how can a person live months after months or even years after years?” (P-15, 20-year-old woman). This absence of culturally significant foods, coupled with the lack of alternative food sources, such as the capacity to grow crops or vegetables (Ahmad, Ramlan, Ladiqi, & Noor, 2020), constitutes the suppression of cultural and traditional food practices, which are denied to those born within the confines of the camps.

Notably, there are some very limited avenues to obtain fish items, but doing so comes at the expense of other essential items. The lack of income prevents Rohingya refugees from purchasing food according to their needs or preferences. As a participant explained,

> Yes, there are options to take fish, meat, etc., from the WFP shop. But we do not take the meat or fish for if we take those items, then the main staple food will be short. Again, as we do not have any preservation system, we have to eat fish and meat within a day or two. So, we do not take fish or meat from the WFP shop. If anyone can earn money, then he can buy some items like fish or meat. (P-30, 45-year-old man)

This excerpt highlights intersectional challenges, encompassing food security, cultural dietary needs, and economic limitations, contributing to the poor health and well-being of Rohingya refugees. The notable absence of access to culturally significant items, such as fish, is a gap in their culinary traditions, impacting their overall well-being. Simultaneously, being unable to seek employment exacerbates their struggles and constrains their capacity to access food that aligns with their cultural preferences.

Resorting to selling food

This theme depicts a form of agency grounded in cultural frameworks within the structure of food rationing. Despite the food scarcity in the camps, selling food items is a prevalent practice for Rohingya refugees, which currently serves as their primary source of income (Malhotra, 2018; WFP, 2018b). With Rohingya refugees being restricted from seeking employment outside of the camps, they lack alternative income sources and thus engage in selling aid (food and nonfood) items to generate money to purchase other necessities. Though one participant said, "Without selling [aid items] we do not have any other way to collect money" (P-10, 21-year-old woman), another participant said, "If we sell any food item to collect money, then in that month we face more difficulties" (P-03, 42-year-old woman). The following excerpt portrays a 27-year-old man's sacrifice of his limited food available to secure a child's education, exemplifying the difficult choices Rohingya refugees are forced to make, with education often being viewed as a pathway to a better future:

> We do not have any income in the camp. Then how can we manage the fees of tuition? The only way to manage the fees is to sell the food ration items in the bazar [market]. I have to sell the food to manage my child's tuition fee. (P-18)

Selling food items was also necessary to purchase some medicines, as mentioned by one participant: "I am an aged woman . . . I need medicines but all medicines I do not get free . . . I do not have any income and so I have to sell the food items to get money to purchase medicines" (P-36, 62-year-old woman). Another participant similarly stated,

> When we need medicines and we do not get those in the hospital then we have to buy those medicines from the pharmacies, but to buy medicines we need money. Finding no other alternative, we sell our food items like rice, oil, etc., in the local market and get some money to buy the required medicines. (P-31, 34-year-old man)

From these excerpts, it seems that Rohingya refugees will be forced to continue selling food items until other necessities of health and well-being are taken care of.

However, some participants expressed grievances about not receiving the fair market price for these items when they engage in such transactions. A participant explained this:

> When we go to the bazar [market] to sell the oil bottle, we get less price. For example, when we get the oil, each bottle costs 150 taka at the WFP food ration shop but when we sell it, we get 100–120 taka per oil bottle. Still, we do not have any alternative, rather to sell the food items to collect some money. (P-15, 20-year-old woman)

Despite the economic disadvantage of receiving significantly less than the purchase price for food items, Rohingya refugees are compelled to sell these items as a means of generating much-needed money for other necessities, highlighting their economic vulnerability and loss of agency situated against structures of inaccessibility, which can have profound consequences on their health and well-being.

Discussion

This study reports on the findings of in-depth 41 interviews with Rohingya refugees residing in camps in Cox's Bazar. The findings from the participant narratives depict how food scarcity is a direct contributor to poor health and works to inhibit agency in the pursuit of health and well-being. The impact of food scarcity on poor health has also been documented by the OHCHR (2023), Shohel (2023), and the UNHCR (2021), which is particularly concerning for the children residing in the camps, whose growth status and immunity are compromised due to insufficient nourishment (Rahman & Islam, 2019). The participants further depicted how their dependence on rations for survival, although intended to aid, paradoxically hinders agency in pursuing health and well-being. This is exacerbated

by economic limitations and the inaccessibility of other essential provisions, driving some participants to the desperate measure of selling their limited food supplies to access some medications and education for their children.

Our study is grounded in Dutta's (2008, 2018) CCA, which positions food insecurity as a manifestation of a structure of inequitable resource distribution. Communities have voiced how experiences of marginalization are tied to hunger or inadequate access to nutritious foods in a range of contexts (e.g., Dutta et al., 2016; Koenig et al., 2012; Tan et al., 2017). Moreover, the CCA asserts that communicative and material inequalities work hand in hand with the erasure of communities situated in the margins of the margins by reproducing and circulating structures of oppression that threaten the health and well-being of these communities (Carter & Alexander, 2020). Such erasure and material inequality are both signified and materialized by the Rohingya refugee camps being separated by gheraoed wired fencing, which prevents them from seeking employment or from leaving except for essential medical treatment (Prodip, 2023). The physical separation of these camps also contributes to erasing awareness of both the food scarcity within them and the plight of Rohingya refugees, who lack communication infrastructures to publicize their situation. The association between erasure and food scarcity can be observed through shifts in aid distribution; in the aftermath of the 2017 exodus, increased visibility prompted donations from Bangladeshi people, but over time, funding and food rations significantly declined. It is now at the point where recent reductions in food rations have raised fears that Rohingya refugees may be pushed to the brink of starvation (Sankar, 2023). In September 2019, a directive was issued prohibiting the donations of financial assistance in the camps, which a government representative related to concerns that refugees could use these funds to acquire illicit identification documents (Ahmed, 2019).

Structural and communication inequalities can also intersect with broader inequalities in food ownership, distribution, and circulation (Carter & Alexander, 2020; Dutta & Thaker, 2020), which frequently play out in social categories involving race, gender, and social class (Schraedley et al., 2020). Undertaking our research necessitated engagement with the majhis—the local Rohingya leaders originally established by the Bangladesh Army (ACAPS, 2018). Doing so unveiled power imbalances within the camps (Rahman, 2022) and this leadership structure has been criticized for contributing to communication gaps in disseminating information within the camps (Toma et al., 2018) and hindering the direct and meaningful participation of some Rohingya refugees in working with humanitarian organizations (United Nations Office for the Coordination of Humanitarian Affairs [OCHA], 2018). Furthermore, the lead researcher encountered four Rohingya refugees who did not have a food ration card, rendering them entirely reliant on the assistance of others. This could have social repercussions within the camps as illustrated by the aforementioned case of a young woman who faced marital difficulties due to this lack of a ration card despite having applied for it.

The CCA also emphasizes the relationship between culture, structure, and agency. Health meanings expressed by participants tended to be constructed within a context of structural absences, where individuals lack access to an adequate quantity of food, nutritious options, and other essential provisions necessary for a healthy life, which worked to reduce agency. Participants further revealed how this could interplay with culture as there is insufficient access to foods in adherence to their traditional diet, known as Sutki-vat (Roy et al., 2022). The substitution of culturally significant foods with unfamiliar staples like dal (lentils), combined with the absence of alternative food sources, including the capacity to grow crops or vegetables (Ahmad et al., 2020), suppresses traditional food practices. This association between the loss of land and food production practices with struggles in healthy

dietary practices has been documented in CCA research in other contexts (e.g., Carter & Alexander, 2020). Consequently, those born within the confines of the Rohingya camps have little experience of these cultural foods. As one participant poignantly articulated, their experiences are akin to living as a "musafir" (stranger), revealing how their situation is inherently tied to displacement.

Ultimately, our study spotlights and advances the understanding of health as fundamentally intertwined with food accessibility within the camps, situated within the culture-structure-agency triad, as an entry point for the development of strategies aimed at enhancing access to basic food supplies. By centering the experiences of Rohingya refugees situated in the margins of the margins, we acknowledge their agency and expertise in navigating the challenges they encounter and in working toward respective solutions. Second, through these interviews, we gain insight into the systemic factors underpinning food scarcity, including structural inequalities and discriminatory policies. By documenting these realities, we lay the groundwork for advocating for policy changes and structural reforms that address the root causes of food insecurity among the Rohingya refugees in Cox's Bazar. Without addressing food scarcity, the health repercussions will continue to be devastating. The food crisis has unleashed a cascade of additional challenges, ranging from heightened levels of child labor, early marriages, and domestic violence to the crucial issue of human trafficking, which was estimated to involve 15,000 Rohingya people between March 2019 and March 2020 (Shishir, 2021). In 2022, more than 3,500 Rohingya refugees resorted to fleeing the refugee camps in Bangladesh through perilous boat journeys across the Andaman Sea and the Bay of Bengal, with at least 348 losing their lives or going missing during these voyages (UNHCR, 2023b). The CCA involves centering voices of hunger in the margins of the margins as a foundational step in developing theoretical frameworks for addressing the dynamics of social change (Dutta et al., 2016).

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5.2.3 Structural barriers to health

Six years since the mass exodus of 2017, Rohingya refugees live in various camps of Bangladesh with limited healthcare facilities. Although some infrastructure developments have occurred in the Rohingya camps of Bangladesh during these six years, there are still various structural barriers that pose a threat to the overall health and wellbeing of the Rohingya refugees. The camp area is around 26 square kilometres with an average population density of 40,000 persons per square kilometre, with some places reaching 70,000 (Mistry et al., 2021; Nasar et al., 2022). The average population density of the Cox's Bazar Rohingya camps is more than 40 times of Bangladesh's average population density. This is a staggering figure considering the fact that Bangladesh is already a densely populated country with an average density of 1,265 people per square kilometre (Islam et al., 2020).

A limited number of healthcare centres, around 175, are now providing service to one million Rohingyas living in the Bangladeshi camps. Of all the health centres, only 17% are round the clock and only three health amenities have surgical facilities (Ahsan, 2020; Barua et al., 2022). The entire refugee camp area of Cox's Bazar has only five field hospitals, with a total 700 hospital beds available for one million Rohingyas. There is no Intensive Care Unit (ICU) or High Dependency Unit (HDU) facility in these field hospitals. The shelters/houses where Rohingyas live are all temporary structures and very close to each other with limited WASH facilities. Each shelter size is barely 10 square metres (107 square feet) and houses an average of five to seven Rohingya people (Alam, 2020b). As the Rohingya society is patriarchal, various social practices and structures restrict women and children from accessing necessary healthcare facilities.

Link Five

A part of chapter 5 [5.2.3 (a)] titled, ““The beggar’s life is better than us”: A culture-centered study in Rohingya refugee camps” has been submitted to the Journal of International & Intercultural Communication.

This article was written on the basis of my findings of research study at Rohingya refugee camps of Bangladesh. Grounded in Culture-Centered Approach, this study explores structural challenges of health faced by Rohingya refugees residing at the 33 camps of Cox’s Bazar. In this article we contribute to addressing health communication gap by centering the voices of 41 Rohingya refugees residing in five refugee camps visited by the author. This article contributes to a growing body of scholarship guided by the ‘margins of the margins’ concept of CCA in the pursuit of meaningful structural transformation. Both of my supervisors, Professor Mohan Dutta and Dr. Akhteruz Zaman, provided feedback on the draft of the article.

5.2.3 (a) "The beggar's life is better than us": A culture-centered study in Rohingya refugee camps

(A submitted article)

Rahman, M. M., Elers, P. & Dutta, M. J. (Submitted). "The beggar's life is better than us": A culture-centered study in Rohingya refugee camps. ***Journal of International & Intercultural Communication.***

Abstract

Rohingya are one of the largest displaced populations globally, yet they have been largely unrepresented in communication scholarship. Grounded in the culture-centered approach, this study explores structural challenges of health among 41 Rohingya refugees residing in bamboo and tarpaulin shelters in Cox's Bazar, Bangladesh. The participants' narratives reveal how structural healthcare inaccessibility intersects with inadequate health communication and unsatisfactory healthcare experiences, within an environment of overcrowded and unsanitary living conditions. Our study recommends increasing resources for healthcare facilities and emphasizes the broader need to address the restrictive policies and laws in Bangladesh. These findings inform a discussion on the role of communication scholars in advocating for underrepresented communities.

Keywords: Rohingya refugees; culture-centered approach; refugee health; 'margins of the margins'

Introduction

It has been stated that, in their homeland Myanmar, Rohingya "do not seem to have the right to have rights" (Rahman, 2024, p. 23). Rohingya constitute one of the largest and

most vulnerable displaced populations globally, with many fleeing Myanmar due to persecution and being denied citizenship rights (UNHCR, 2023). Cox's Bazar, Bangladesh, is home to nearly one million Rohingya (UNHCR, 2023), yet the country refuses to recognize Rohingya as refugees, thereby denying them their associated rights (Dempster & Sakib, 2021). Many Rohingya reside in refugee camps in Cox's Bazar comprising temporary bamboo and plastic shelters, with population densities reaching up to 70,000 people per square kilometer (Islam, 2023; Sullivan, 2022). Inadequate sanitation and healthcare contribute to widespread health challenges, including malnutrition and communicable diseases (MSF, 2023; Jegan, 2023). Despite international humanitarian efforts, Rohingya refugees continue to face significant obstacles to their well-being, further exacerbated by a shortfall in humanitarian aid (HRW, 2018; Chowdhury, 2023). In this context, academic research can play a crucial role in understanding how refugees navigate communication barriers, health challenges, and socio-political dynamics within camp environments to inform interventions and advocacy efforts aimed at addressing their specific needs.

In the present study, we center the voices of Rohingya refugees residing in bamboo and tarpaulin shelters in refugee camps in Cox's Bazar, Bangladesh. Underpinned by Dutta's (2008, 2018) culture-centered approach – a framework that works with marginalized communities in understanding health meanings constructed at the intersection of structure, culture, and agency – we undertook 41 interviews with Rohingya refugees in the camps to explore structural challenges of health. The participants' narratives reveal how structural healthcare inaccessibility intersect with dissatisfactory health communication and healthcare experiences. These struggles are exacerbated by the congested shelters and unsanitary camp conditions, highlighting the multifaceted nature of the challenges to health and wellbeing. Our study offers insights into health communication processes in the refugee camps and

inform a discussion about the role of communication scholars in advocating for underrepresented communities.

Literature review: Contextualizing health crises in communication scholarship

The need to contextualize contemporary health crises beyond a biomedical framework was emphasized by Farmer (2004a), who stated, "Any thorough understanding of the modern epidemics of AIDS and tuberculosis in Haiti or elsewhere in the postcolonial world requires a thorough knowledge of history and political economy" (p. 305). This perspective is supported by research showing how the challenges faced by refugees intersect with broader structures of inequality, revealing unmet health needs across various settings (Hahn et al., 2019; Mangrio et al., 2017; Patel et al., 2021). Farmer (2004a, 2004b) refers to these intersecting forces that create and perpetuate inequality as structural violence. Although neoliberal discourse often frames migration as a matter of agency and opportunity, it overlooks how structural disenfranchisement can drive migration (Dutta, 2017; Dutta & Kaur-Gill, 2018). Migration thus extends beyond mere physical movement and is deeply embedded in geopolitical, economic, cultural, and historical power dynamics (Cresswell, 2006), intersecting with issues of state power, class, race, and gender.

Nevertheless, many refugee communities continue to be obscured behind an 'invisible wall' (Welsh, 2021), receiving minimal academic attention regarding their communication needs (Chouliaraki & Georgiou, 2017; Witteborn, 2011). Despite this, there has been a growing body of research on refugee communities that reveals the multifaceted dimensions of their post-migration experiences (e.g., Mitra, 2011; Witteborn, 2008). For instance, Kinefuchi (2010) investigated the post-migration identity formation of Montagnard men, in the United

States illustrating the complex process of negotiating cultural heritage alongside adaptation to new societal norms. Bishop (2022) examined the impact of nonverbal communication and emotional displays in asylum interviews and hearings while, Elers et al. (2023) focused on information challenges among Afghan women during a COVID-19 lockdown in New Zealand. These studies provide insights into migration challenges and reveal the need for increased scholarly attention to refugee communities.

While valuable, communication research with refugee communities often focuses on those in first world contexts and does not adequately represent Rohingya communities. The first and third authors conducted a study with Rohingya refugees in New Zealand, centering on their pre-flight experiences, the perilous journey by boat, and the subsequent post-flight experiences (Rahman & Dutta, 2023). However, the lived realities vary significantly among those currently residing in refugee camps in Bangladesh. Examining perspectives within these camps is valuable because it provides insights into their navigation of communication barriers, health challenges, and socio-political dynamics within the camp environment. By centering the voices of Rohingya refugees, our study aims to inform humanitarian policies, interventions, and advocacy efforts to address their specific needs and promoting social justice in displacement contexts. Against this backdrop, the present study explores:

> *QR: What are the structural health challenges faced by Rohingya refugees within the refugee camps located in Cox's Bazar, Bangladesh?*

Rohingya refugees

Rohingya are a religious, ethnic minority group of Myanmar where they have lived for centuries, but since 1982, they have been rendered stateless (UNHCR, 2023). As a result, nearly one million Rohingya refugees have sought shelter in 33 makeshift camps in Cox's

Bazar, Bangladesh (Rahman, 2023), including the world's largest refugee camp which is predominantly occupied Rohingya refugees (UNHCR, 2023). These camps have staggering population densities, with an average of 40,000 people per square kilometre and some areas reaching as high as 70,000 (Ahmed et al., 2021). They are not allowed to leave the camps without permission, which are patrolled and guarded by Bangladeshi security forces, including the Armed Police Battalion (Islam, 2023). Rohingya are typically granted permission only in emergencies, such as medical needs (Sullivan, 2022). This restriction severely limits their freedom and opportunities for employment.

Rohingya refugees face numerous challenges in the camps. As the construction of permanent shelters is prohibited (Sullivan, 2022), the camp's reliance on temporary shelters made of bamboo and plastic sheeting make the Rohingya refugees vulnerable to natural disasters which the area is prone, with strong winds, torrential rains, flash floods, and landslides often destroying their makeshift homes (Ahmed et al., 2021). There were also 222 fire incidents in the camp area between January 2021 and December 2022, which made many Rohingya refugees homeless (Guinto & Moloney, 2023). The crowded and unsanitary living conditions in the camps have serious implications for the Rohingya's health. Malnutrition and low immunization coverage increase their susceptibility to various diseases, including diarrhea, cholera, and scabies (MSF, 2023). Moreover, most of the camp's population consists of children and women (UNHCR, 2023), and acute malnutrition among children under five years old is a pressing issue (Jegan, 2023).

The Government of Bangladesh does not recognize Rohingya as refugees, rather calling them ‘Forcibly Displaced Myanmar Nationals’ and denying their rights as refugees. Without having recognized legal status in Bangladesh, Rohingya face restricted access to

employment and dependency on severely limited humanitarian aid (HRW, 2018), which continues to decline (Chowdhury, 2023). The current funding shortfall is dire, with only 30 percent of the required funds for Rohingya secured as of August 2023 (MSF, 2023). Due to this financial deficit, the World Food Programme (WFP) slashed the food ration for the Rohingya twice in 2023, resulting in each refugee receiving only $8 per month. Analysts predict that this reduction in rations will lead to increased malnutrition, heightened susceptibility to diseases, and overall compromised health outcomes (HRW, 2023). Aid agencies provide a limited depiction of some of the challenges to health and wellbeing within these refugee camps (e.g., HRW, 2023; MSF, 2023). While this is valuable for immediate interventions and policy recommendations, academic research offers a more in-depth and nuanced exploration of the lived experiences and challenges faced by the Rohingya population.

Materials and methods

The process of engaging with Rohingya refugees presents multifaceted challenges that are entwined with issues of voice inequality. Accessing the Rohingya refugee camps mandates approval from the Bangladesh government's Refugee Relief and Repatriation Commissioner’s office, serving as an initial hurdle. Once within the camps, navigating through structural and cultural contexts involves engaging with Majhi, the Rohingya camp leaders, during the first visit to each camp, and conducting research with cultural sensitivity. For female participants, this involved seeking permission from male partners who were also present during the interviews.

Language emerged as another significant challenge and translation was the only feasible way to represent Rohingya voices. The first author worked with a male Rohingya

community researcher who acted as a cultural negotiator in aiding in participant recruitment and assisting in translating interviews (between Bengali and Rohingya). The first author's proficiency in both Bengali and Rohingya languages enabled his validation of the community researcher's translations. The first author then translated the recorded interviews into English, which was verified by the third author proficient in Bengali and English. However, while we took care to ensure the best possible translation within the given circumstances, we are critically aware of the limitations of reconstituting meanings in English. As Spivak (2000) asserted, "In every possible sense, translation is necessary but impossible" (p. 13); while translation is an important tool for communication and understanding, it often remains inherently incomplete due to the cultural and contextual nuances embedded in language.

To enhance the interpretation process and as a key tenet of the culture-centered approach (Dutta, 2018), self-reflexivity played a crucial role throughout every stage of the research. This practice was integral during fieldwork, analysis, and in our ongoing discussions as researchers with one another as researchers (for a breakdown of this process within the culture-centered approach, see Elers et al., 2021). Researchers consistently engaged in introspection, acknowledging their own positionality, biases, and predispositions, which facilitated critical self-awareness and reflection (see Corlett & Mavin, 2018).

The culture-centered approach

The culture-centered approach involves actively working to address the erasure of marginalized voices in dominant structures of health communication (Dutta, 2008, 2018). It foregrounds the narratives of marginalized community members to uncover inequalities within dominant structures and advocates for a reconfigured, community-led approach to health communication (Basu & Dutta, 2008; Dutta, 2018; Dutta et al., 2019).

Communication inequality is conceptualized as being interrelated with structural power inequality (Sastry et al., 2021): for as Dutta (2012) stated, “At the heart of communication marginalization lies economic inaccessibility to power structures within mainstream systems, which consequently set the rules, languages, techniques, and procedures for communicative participation” (p. 5). Thus, the approach emphasizes the importance of voice infrastructures in developing strategies to enhance community health and wellbeing and as a vehicle to contribute community insights to public discourse, policy development and decision-making (Dutta, 2008).

Dutta’s (2008, 2018) culture-centered approach situates culture (the everyday construction of shared meanings) and structure (the distribution of resources mediated through power) in an interrelationship with agency, which is positioned as a source of social change, recognizing the capacity for community-led transformation. Structural inequities are examined through the lens of the "margins of the margins" concept (Elers & Dutta, 2023), which involves scrutinizing the representation of voice in seeking out participants, considering who is not present within dominant discursive spaces and what voices in the margins are missing in the research processes (for examples, see Dutta et al., 2024, 2019). Through this framework, the culture-centered approach recognizes the multi-layered nature of inequalities and silencing mechanisms that lead to erasure. Rejecting essentialist perspectives, this approach acknowledges the dynamic nature of culture, while recognizing how culture is imbued in various (and often intersecting) forms of inequality (Dutta, 2008).

Unlike dominant cultural sensitivity approaches, which adapt health messages to the cultural markers of the target audience but do not address structural inequalities and thus reinforce the status quo, the culture-centered approach is committed to working with

communities to develop theories and applications from within the culture itself (Dutta, 2007, 2008). The essence of undertaking fieldwork grounded in the culture-centered approach lies in the researcher's ongoing presence within communities over time as an “embodied practice of resistance” (Dutta et al., 2019, p. 1). This approach utilizes qualitative, in-person methods, beginning with interviews and ethnography, followed by the establishment of a local advisory board to oversee the research processes (Dutta, 2008, 2018).

The culture-centered approach has been applied in various settings globally, including among migrant communities (e.g., Dutta, 2017b; Dutta & Jamil, 2013; Koenig et al., 2012). In 2018, Dutta outlined four conceptual anchors of the culture centered approach based on participation, partnerships, communication infrastructures, and reflexivity. Emphasizing community engagement and dialogue, the culture-centered approach engages with community members in identifying health concerns and respective solutions in keeping with the community context and needs. The culture-centered approach also advocates for forging partnerships with external stakeholders to challenge prevailing power structures if feasible, while the development of communication infrastructures enables communities to access communication resources. Reflexivity within the culture-centered approach involves critically examining power dynamics between academics and communities (see Elers et al., 2021), ensuring that community priorities remain distinct from expert-driven agendas.

Methods

This study reports on the findings of 41 in-depth interviews with Rohingya residing in these refugee camps. Study procedures were reviewed and deemed to be low risk through Massey University's ethics procedures. Formal permissions were also granted by the Bangladesh government office of the Refugee Relief and Repatriation Commissioner (RRRC) to conduct

research in the Rohingya refugee camps. The first author has been engaging with Rohingya refugees since in 2017 while employed as a journalist in Bangladesh, providing a foundation for understanding the contextual nuances. The third author has valuable experience in researching Rohingya refugees across various global contexts.

The interviews were undertaken by the first author between December 2021 and January 2022 in five refugee camps of Ukhiya Upazila in Cox's Bazar, Bangladesh, following two prior visits in July 2018 and February 2020 during the development of the interview questions. These questions were developed to explore challenges to health in the camps, serving as entry points for meaningful discussions. In consistence with the culture-centered approach, the questions concerned challenges to health and how these challenges are situated within broader contexts, concluding with envisioned solutions for addressing the identified challenges moving forward. The interview guide is detailed in Table 1.

[Insert table 1 here]

Each participant was provided with 100 taka (approximately 1 USD) as compensation for their time. We acknowledge that the use of financial compensation in qualitative research is a subject of debate, with concerns about it potentially exacerbating power imbalances between participants and researchers (e.g., Russell et al., 2000). As culture-centered researchers, we are also mindful that meanings of such compensation vary across different contexts. In determining the compensation, we considered the lead researcher's previous experience in these settings, the input from the Rohingya community researcher, and the fact that the standard food ration is 8 USD per month. Before any interviews took place, the researcher reviewed the information sheets with participants, clarifying that they were not

required to answer all questions, that there were no correct answers, and that they could withdraw at any time while still receiving the compensation.

A purposive and snowball sampling technique was used to identify participants, with a Rohingya community researcher identifying initial potential participants. Participants were required to be at least 18 years old, reside within a Rohingya refugee camp, and have the capacity to provide informed consent. Participants provided informed consent prior to the interviews taking place, which lasted between 30 and 90-minutes and were conducted within the participants' dwellings. All participants had resided in Bangladesh for at least five years, with a significant proportion having resided there for over a decade (16 out of 41). Information regarding the participants' gender, age, and their distribution across the camps is provided in table 2.

[Insert table 2 here]

Audio recordings of the interviews were made with prior consent from the Rohingya participants, ensuring accuracy and preserving the authenticity of their responses while fieldnotes captured additional contextual information. The transcripts were anonymized, and participants were assigned participant numbers. To make sense of the collected data, a co-constructivist grounded theory approach (Charmaz, 2000) was employed. Researchers meticulously conducted line-by-line analyses of the final transcripts, encompassing open coding, axial coding, and selective coding to systematically identify key themes.

Results

The Rohingya refugee camps in Cox's Bazar, Bangladesh, are spaces of extreme marginality. Symbolic of deep-seated disparities, these spaces are separated from the surrounding society through wired fencing and a visible armed military presence. Within the 26 square kilometre area of Cox's Bazar around one million Rohingya reside in bamboo and tarpaulin shelters (Zahed, 2020) and there are only about 175 active healthcare facilities (RRRC, 2023; World Health Organization, 2021). In these confined spaces of ethnic division, the narratives of Rohingya refugees expose formidable structural challenges to accessing healthcare. There is a glaring shortage of healthcare professionals, as documented by a ratio of only 0.31 physicians per 1000 people compared to the World Health Organization recommended minimum of 4.5 physicians per 1000 population (Akter et al., 2021).

The participants' narratives reveal three overarching themes: Inaccessible Care, depicting limited access to essential medicines and healthcare facilities; Poor Interpersonal Care, revealing dissatisfaction with the attitudes and communication of medical staff; and Unhealthy Environments, highlighting congested and unsanitary living conditions. These challenges are interwoven, highlighting the need to address multifaceted structural determinants to improve the health and well-being of Rohingya refugees in Cox's Bazar, Bangladesh.

Theme 1: Inaccessible care

"If we cannot manage money, then we have to wait for death." (27-year-old man)

P.02 made the above statement describing the process to receive medical care outside the refugee camps. Healthcare accessibility within the camps is clearly insufficient, with participants describing how there is "Only 1-2 doctors but the number of patients is 400-500

per day" (P.01, 43-year-old man) and long waiting times, whereby "we have to wait even a day to get any treatment" (P.08, 25-year-old woman). There are inadequate resources within these healthcare facilities, such as "…no diagnostic facility" (P.03, 42-year-old woman) and a severe "…shortage of medicines" (P.29, 76-year-old man). Permission for healthcare outside of the heavily guarded camps is subject to approval by the Camp-In-Charge, the administrative head of the refugee camp appointed by the Bangladeshi government (OCHA, 2019) and a doctor's referral letter. The refugees are then confronted with the logistical challenges and transportation costs. For example, a participant stated, "To manage the transport cost is also an extra load for us" (P.15, 20-year-old woman). This forces many participants to sell food rations to receive medical care due to the prohibition of employment.

This results in a frustrating cycle of extended waiting times and insufficient care. Some shared instances where prolonged waiting hindered their access to care: "Once I had too much fever. Then I went to the hospital and queued to visit the doctor… Then after waiting for hours, I came back without getting any medicines" (P.12, 25-year-old man) and "Sometimes I have to return back from the hospital without visiting any doctor" (P.24, 23-year-old woman). Another participant explained:

> The health centers mean paracetamol centers to us. They do not give any test rather whenever we visit, they give us paracetamol. Even when we go to the field hospital, we get paracetamol. Even after waiting for the whole day, we only get paracetamol. (P.03 25-year-old man)

In this excerpt, P.03 reveals a notable absence of diagnostic assessments and a reliance on paracetamol (a medication used to treat fever and mild-to-moderate pain) to the point that these facilities are viewed as "paracetamol centers". This sentiment was echoed by

an elderly Rohingya man who pointed out the critical "shortage of medicines in the health centers/hospitals. As a result, maximum time we get paracetamol, a syrup type of medicine… I have pain in my stomach, but they give me paracetamol" (P.29, 76-year-old man). Consequently, patients are left grappling with the frustration of receiving a superficial remedy rather than comprehensive healthcare to address their specific needs.

This concern is particularly pronounced for severe conditions given that "serious diseases like diabetes, blood pressure et cetera do not have any treatment facility here in the camps" (P.02, 27-year-old man). Participants relayed heartfelt experiences of suffering from health conditions without access to adequate treatments or medical care, sharing "Some Rohingya say that I had Epilepsy disease. But it does not have any treatment in the camp area. As a result, I am continuing to live with this disease" (P.11, 66-year-old man) and:

> I am suffering from diabetes, and also diagnosed a tumor in my belly. But there is no treatment of the diabetes, or tumor in the camp. 2-3 times I had to go outside of the camps for checking and find out the treatment. But the doctors said the tumor operation is not possible in Cox's Bazar but need to go to Dhaka. But I could not manage the money and live with the tumor and diabetes. (P.03 42-year-old woman)

These participants reported the absence of treatment for their conditions within the camp and insurmountable cost of treatment and transport to hospitals outside the camp. The prospect of not being able to afford treatment highlights the urgent need to address healthcare inaccessibility within the camps.

Theme 2: Poor interpersonal care and communication

> [The medical staff] are just doing their job, [they] don't think it is a service of humanity… Our treatment is now hands of those selfish people (25-year-old man).

In the above excerpt, P.12 reflects a feeling of disillusionment with the medical staff whom he perceives as lacking empathy or compassion, as well as a sense of diminished agency due to the lack of options in receiving medical care. Concerns about poor interpersonal care and communication from medical staff were expressed by many participants, describing how "The attitudes of doctors… are not good. They just neglect us" (P.18, 27-year-old man), "they [medical staff] do not behave in a good way with the Rohingya people" (P.21, 30-year-old woman) and "they even do not want to talk to us comfortably" (P.24, 23-year-old woman). Language barriers compounded difficulties in interpersonal health communication, as "Not all the doctors understand the Rohingya language … No specialized interpreter in the hospital" (P.08, 25-year-old woman), although there have been improvements in bridging this linguistic gap among some doctors.

Some participants depicted how structural inaccessibility exacerbates issues of inadequate interpersonal care and communication within an environment where "We are about 18000 people living here and for 18,000 people there is only one health center" (P.24, 23-year-old woman). For instance, P.37 expressed how structural constraints affect the doctors' interpersonal communication:

> The doctors in the hospitals try to give their full support for the Rohingya patients. But problem is that we are too many people. Every day more than 500 people visit the hospital. As a result, we do not get the normal behavior from a doctor. Sometimes they shout to manage the overflow of the patients. (64-year-old man)

In the above excerpt, P.37 states that the doctors "try to give their full support" to their patients – a perspective not shared by all participants. Nevertheless, it was clear that the sheer volume of people seeking medical attention is a hindrance to providing the expected level of care. By emphasizing how the overwhelming number of patients results in suboptimal doctor-patient interactions, including instances of shouting, he illustrates how the high demand for medical services has tangible effects on the quality of interpersonal communication and the delivery of care.

Several participants conveyed a sense of deterioration in interpersonal communication and attitudes among medical staff since the significant exodus of 2017: "when we came in 2017, at that time the doctors' attitude was good. Now they are not interested in giving us proper treatment" (P.18, 27-year-old man) and "When we came in 2017, then we got better treatment and better behavior from the doctors" (P.21, 30-year-old woman). This decline in the quality of care was once again linked to structural inaccessibility, as P.22 observed: "Previously when there were fewer Rohingya in this area (before 2017), we got better behavior from the doctors. Now, their behavior has changed. They even do not want to talk to us. Still, there are some good doctors" (57-year-old woman). These accounts collectively highlight a perceived decline in both the demeanor and communication of medical staff, with participants attributing these changes to the increasing number of refugees and the resulting structural challenges in healthcare provision.

Other participants portrayed the environment of receiving medical care as dehumanizing and disempowering:

> If we talk to the doctor to give us some diagnostic test, they become anger with us. The doctors told us that "do you know better than us?" Then what we can do, just

> receive the medicines what they give. If we talk more there may be possibility of call the police by the doctor and if police come, they will arrest us. The police will listen and believe the doctors speech, not the uneducated Rohingya speech. (P.41, 27-year-old man)

The description of doctors becoming angered when questioned highlights a lack of empathy on their part. The threat of involving the police instils a sense of fear and reinforces the vulnerability of the Rohingya refugees, underpinned by a systemic bias that favours the doctors' perspective over that of the patients. This power dynamic contributes to a dehumanizing experience and reduces the agency of Rohingya refugees in pursuing adequate healthcare.

Theme 3: Unhealthy environments

> We all are living with poverty. In Bangladesh, the beggar's life is better than us. (36-year-old woman)

P.27 made the above statement when describing the struggle without income or resources. Her claim that Bangladeshi beggars' existence is better than their own illustrates the depth of destitution and deprivation faced by the Rohingya community, where even the most marginalized in the surrounding society have a comparatively better standard of living. Participant narratives and researcher observations clearly indicate that the challenges in accessing healthcare are set against a backdrop of unhealthy living conditions. For instance, participants described severe overcrowding, such as: "Our shelter has two different rooms and staying ten people together" (P.15, 20-year-old woman) and "There are now four families living in this shelter. Two separate rooms have been created within the shelter" (P.25, 24-year-old woman). Most of the bamboo and tarpaulin shelters have no windows for air

ventilation or light: “this shelter has no window. Not only mine but also any of the shelter in the camp area do not have any window” (P.04, 42-year-old woman). As a result: “when the cooking is going on, the smoke could not go out from our houses and so we are easily attacked by diseases” (P.08, 25-year-old woman).

These living conditions lead to continuous health risks. Participant stated: “A person may be sick anytime. As we are living here many people in a smaller area then many of us often attack by many diseases.” (P.01, 43-year-old man) and “We become sick because our living style is not good… The waste materials are found all over the places of the camp. I think the dirty environment and poor nutrition are the main causes for our sickness” (P.36, 62-year-old woman). The environmental factors contributing to prevalent illnesses are further discussed in the following excerpt:

> The drains and the latrines are very close to my shelter. As a result, flies/bad smells come out of those places and enter my shelter. So, it is another difficulty of mine to lead a good life. The flies are the carrier of many diseases, and we are attacked by them. Diarrhoea is very common not only in my family but also overall the camp area. (P.20 22-year-old man)

In this excerpt, P.20 directly attributes illnesses to the unfavourable living conditions, including vulnerability to diseases carried by flies from the inadequate sewerage systems, illustrating the deplorable state of their surroundings.

Furthermore, given Bangladesh's tropical climate, elevated temperatures and intense rainfall further deteriorate the living conditions within the temporary shelters of the camps. The absence of electricity means that the heat in the summer “creates a lot of sufferings”

(P.15, 28-year-old woman) and “makes our lives more miserable during the hot days” (P.30, 45-year-old man). Another participant stated:

> During the summer season due to too much hot temperature it is difficult for us to stay inside the shelter. We do not have any electricity in the camp area and so no fans can be run by us. As a result, we always sweat in the shelter during the hot days. In this country of Bangladesh only we get winter for only three months. The rest of the months we face trouble with the high temperature. (P.24, 23-year-old-woman)

The above excerpt reveals how the disproportionally short winter season leaves the community grappling with oppressive high temperatures for most of the year.

Participants further highlighted the persistent challenges stemming from the unaddressed condition of their shelters, which have lacked repairs for the past five years. This issue significantly impacts them, including during winter, when: “The rainwater easily drips into my shelter. Various nights I had to sit down by carrying my child in my lap as the rainwater came into my shelter” (P.19, 25-year-old-woman). The inadequate drainage system has led to overflowing drains and the subsequent proliferation of diseases: “During the rainy season, if heavy rain occurs the drains overflow, and the waste materials are spitted on the open space and cause diseases” (P.28, 36-year-old-man). The poor living conditions endured by the Rohingya refugees highlight how resolving healthcare challenges alone may not suffice without addressing broader determinants of health, such as proper sanitation and adequate housing.

Discussion

The Rohingya refugee camps in Cox's Bazar, Bangladesh are characterized by extreme marginality. The overcrowded, windowless bamboo and tarpaulin shelters, combined with poor sanitation, and drainage issues, make the Rohingya refugees highly vulnerable to diseases (as also documented by Halder et al., 2023). A survey of 361 residencies across 19 Rohingya refugee camps in Bangladesh determined that three quarters had overflowing latrines and half had visible feces (MSF, 2022). Diarrhea remains the leading cause of death among Rohingya children under five-years old (Al Fidah, 2023). The inaccessibility of medical care, also documented by Khan et al. (2021) and Saiyed et al. (2018), lead to insufficient treatment and unmet medical needs. The Rohingya refugees often suffer with health conditions and can be forced to "wait for death" (27-year-old participant) if they are unable to afford treatment outside of the camps. This structural inaccessibility to healthcare is compounded by dissatisfaction with medical staff attitudes and communication, with some participants describing dehumanizing experiences that undermine their agency to pursue adequate care.

One participant expressed a profound sense of deprivation and marginalization with the statement: "In Bangladesh, the beggar's life is better than us." While evaluating the validity of such a comparison is beyond the scope of our research, the sentiment reflects a deep feeling of extreme disadvantage and erasure, highlighting the exclusion of Rohingya from resources even the most marginalized in the host society might access. This comparison is grounded in broader systemic issues affecting their lives, set against a backdrop of historical persecution and socio-economic challenges (MSF, 2023; UNHCR, 2023), where Rohingya are not recognized as refugees by the Bangladeshi Government (Dempster & Sakib, 2021). Farmer (2004b) describes these extreme health inequities as structural violence, which shapes the nature and distribution of suffering and reveals deeper pathologies of power

that determine who suffer abuse and who is protected from harm. Farmer's (2004b) work exposes the dehumanization inherent in denying specific communities adequate healthcare, questioning: "If access to health care is considered a human right, who is considered human enough to have that right?" (p. 206).

Our study contributes to culture-centered scholarship that demonstrates how structural factors limit health choices by shaping patterns of unequal access to resources (Sastry et al., 2021). The Rohingya refugees in Cox's Bazar, Bangladesh are situated in the 'margins of the margins,' and remain absent from communication scholarship, aside from the contributions of the first and third authors in another context (Rahman & Dutta, 2023). The narratives of the Rohingya refugees in Cox's Bazar, Bangladesh highlight the urgent need for medical staff to improve interpersonal communication, increase healthcare accessibility, and address the poor sanitation and housing within the camps. However, these improvements are unlikely without addressing the underlying structural challenges. Restrictive Bangladeshi policy and laws inhibit access to alternative healthcare (World Health Organization, 2021), permanent shelter construction (Sullivan, 2022), and employment (HRW, 2018), denying the refugee rights of the Rohingya people. Addressing these multifaceted challenges requires broader structural transformation, and the communication discipline can play a role in advocating for the representation of Rohingya voices within dominant discursive spaces to foster broader societal change.

Our study also demonstrates the complexities of marginalization and power inequalities in Third World settings. Undertaking this research involved navigating significant challenges, including obtaining approval from the Bangladesh government's Refugee Relief and Repatriation Commissioner's office and the Camp-In-Charge (the

administrative head of each refugee camp appointed by the Bangladeshi government). The first author also engaged with local majhi (Rohingya leaders established by Bangladeshi authorities) and female participants with the approval of their partners. Rohingya women experience high rates of gender-based violence and abuse in the camps (Priddy et al., 2022) and cannot leave their shelters without the accompaniment or permission of a male family member (Tripura, 2022), which can impact their ability to seek medical care. These considerations are essential for conducting research within the camps underpinned by the culture-centered approach, which requires being physically present in communities over time (Dutta et al., 2019) and is committed to developing theories and applications from within the culture itself (Dutta, 2007, 2008).

We call for further communication research to address structural inequity and actively work with communities situated in the global margins to promote structural transformation. Persistent inequities of race, place, and gender among the communication 'citation elite' (Chakravartty et al., 2018; Freelon et al., 2023) reflect a broader issue where communication research predominantly originates from Western, privileged settings (Wasserman, 2020), neglecting populations disproportionately affected by health disparities. While progress toward inclusivity has been made within the communication discipline, there remains the need to center the voices and experiences of marginalized communities in addressing health disparities, ensuring that diversity initiatives substantively engage with those most vulnerable and in need of scholarly attention and support. Although refugees have been largely overlooked in communication research, existing studies highlight the crucial need to explore and amplify these voices (e.g., Chouliaraki & Georgiou, 2017; Witteborn, 2011).

Declaration of interest statement

There are no conflicts of interest to declare.

Funding details

This research did not receive funding from sources external to the university.

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Table 1: Interview guide

Topic	Questions / Probes
General	আপনি এখন কেমন আছেন? (How are you, now?) আপনি কবে প্রথম বাংলাদেশে এসেছেন? (When did you first come to Bangladesh?) Probes: • এটা কি আপনার বাংলাদেশে প্রথম আসা? (Is that your first-time entry into Bangladesh?) • বাংলাদেশে আসার পর সর্ব প্রথমে আপনি কোথায় ছিলেন? এবং কতদিন ছিলেন? (Where did you take shelter after coming to Bangladesh and how long you stayed there?) • এই ক্যাম্পে কবে এসেছেন? (When did you come to this camp?)
Housing	এখানে বাস করতে কী কী কষ্ট হয়? (What difficulties do you face to live in your shelter?) Probes: • আপনি যেখানে বাস করছেন এটা কি আপনি নিজে বানিয়েছেন নাকি সরকার তৈরি করে দিয়েছে? (The shelter where you are now living, is that made by you or supplied by Bangladesh Govt?) • বাসস্থানের এই জমি কি কিনতে হয়েছে নাকি সরকার দিয়েছে? (Did you need to purchase the land for your shelter?) • নিজেকে জমি কিনতে কত টাকা দিতে হয়েছে? (How much money did you to give landlord to buy this land?) • এই বাসস্থানে আপনারা কতজন বসবাস করেন? (How many people live in your shelter?) • এখানে বসবাসের শুরুর পর থেকে কি এই বাসস্থানের কোনো মেরামত করতে হয়েছে? (Has there been any repairs to this shelter since the start of your living?)
Food	ক্যাম্পে কিভাবে বেঁচে আছেন? (How are you living in the camp?) Probes: • যে রেশন পান তা দিয়ে কি সংসার চলে? (Does the family survive on the food ration they get?) • রেশনে কি কি পান? (What items do you get in the food ration?) • প্রতিমাসে কি একই খাবার আইটেম পান, নাকি ভিন্ন? (Do you get the same food item each month, or different ones?) • আপনি কি চাইলে কোনো কিছু বাজার থেকে কিনতে পারেন? (You can buy anything from the market as per your wish?) • আপনাদের প্রধান খাবার কি? মিয়ানমার এবং এই ক্যাম্পে খাবারের মধ্যে কী পার্থক্য আছে? (What is your staple food? What is the difference between the food in Myanmar and this camp?)
Facilities	আপনার ক্যাম্পে কী কোনো বিদ্যুৎ সরবরাহ আছে? (Does your camp have any electricity facility? Probes: • এই ক্যাম্পে কতজনের জন্য একটি ল্যাট্রিন? (A single latrine is for how many people in this camp?) • কতজনের জন্য একটি গোসলখানা? (How many people use a single bathroom in this camp?) • খাবার পানি কোথা থেকে পান? (From where you get the drinking water?) • আপনার কি মোবাইল ফোন আছে? (Do you have mobile phone?) • মোবাইল কিভাবে রিচার্জ করেন? (How do your charge your mobile? • ক্যাম্পে মোবাইলের নেটওয়ার্ক কেমন? (How is the mobile network in the camp?) • ক্যাম্পে খাবার কিভাবে রান্না করেন? (How do you cook food in the

	camp?) • যে এল পি জি গ্যাস সিলিন্ডার পান, তা দিয়ে কি মাস চলে? (Does your LPG cylinder enough for your family cooking for a month?) • এ জীবনে পড়াশোনার সুযোগ পেয়েছেন? (Do you get any opportunity of education in your life?) • বাচ্চারা কি পড়াশোনা করে? পড়লে কি পড়ে? (Do your kids study? If yes, where do they study)
Health construct-ions and services	আপনি স্বাস্থ্য বলতে কি বোঝেন? (What do you mean by health? আপনার স্বাস্থ্যগত সমস্যা আপনি কিভাবে মোকামেলা করেন? How do you deal with your health problems? পরিবারের কেউ অসুস্থ হলে কোথায় যান? (Where do you go if someone in the family becomes sick? Probes • আপনার ক্যাম্পে কি কোনো স্বাস্থ্য কেন্দ্র আছে? থাকলে কয়টি আছে? (Is there a health center in your camp? If so, how many are there?) • আপনার ক্যাম্প থেকে ফিল্ড হাসপাতালের দূরত্ব কত? (How far is the field hospital from your camp?) • অসুস্থ হলে কোথায় যান, স্বাস্থ্য কেন্দ্র নাকি ফিল্ড হাসপাতাল? (If sick, where do you go, health center or field hospital? • হাসপাতাল কিংবা স্বাস্থ্য কেন্দ্রে ডাক্তার কি সব সময় থাকে? Is there always a doctor in the hospital or health center? • ডাক্তারদের ব্যবহার কেমন? (How is the attitude/behaviour of the doctors?) • হাসপাতাল কিংবা স্বাস্থ্য কেন্দ্রে কতক্ষন অপেক্ষা করতে হয়? (How long to wait at the hospital or health center?) • ঔষধ কি বিনা পয়সায় পান নাকি টাকা দিতে হয়? (Do you get medicine for free or do you have to pay?) • হাসপাতাল কিংবা স্বাস্থ্য কেন্দ্রে কি কি ঔষধ পান? (What medicines do you get at the hospital or health center?) • নিজের টাকায় কি কখনো ঔষধ কিনে খেয়েছেন? কি কারণে কিনেছেন? (Have you ever bought medicine with your own money? Why did you buy it?)
Solutions going forward	অনেক দিন যাবৎ তো এই ক্যাম্পে আছেন। কি করলে আপনাদের এখানে থাকা আরো ভালো হতে পারে? (You have been in this camp for a long time. What are your suggestions to make your stay here better?)

Table 2: Participant information

	Number of participants (total = 41)	Proportion of total (%)
Gender		
Male	19	46.3
Female	22	53.7
Age		
18-34	23	56.1
35-54	9	22.0
55+	9	22.0
Refugee camp		
Camp 1	13	31.7
Camp 2	5	12.2
Camp 3	9	22
Camp 4	10	24.4
Camp 5	4	9.7

Chapter 6: Discussion

6.1 Introduction

Six years after fleeing violence from Myanmar, Rohingya refugees face significant health risks in the camps of Bangladesh. The Rohingyas are entirely dependent on food rations as they are not allowed to leave the camps or work outside. Each Rohingya individual is now dependent on 27 US cents per day for their livelihood (Save the Children, 2023). With the food aid cut twice by the World Food Programme in 2023, each Rohingya in the camps of Bangladesh is now entitled to receive food rations amounting to just US$8 per month. In just six months, from March to September 2023, the Rohingyas living in the camps saw this significant cut in food aid. The Rohingya refugees' health and nutrition will be negatively affected due to these cuts. Even before the first round of ration cuts in March 2023, the overall health of the Rohingya camp inmates was in bad shape, with 45% families lacking a sufficient diet, and widespread malnutrition (Mahmud, 2023). Thus, the devastating consequences of food aid cuts on the health of Rohingya refugees are easily understandable.

According to Dutta's (2008) Culture-Centred Approach, the Rohingya refugees living in the Bangladeshi camps epitomise the 'margins of the margins' community as they survived the atrocities perpetuated by the Myanmar authorities. Their overall health and well-being are totally dependent on limited international food aid that has decreased over time, which, in turn, increased Rohingyas' marginality on health

6.2 Rohingya construction of health

The World Health Organization (WHO) defines health as “a complete state of physical, mental and social wellbeing, and not merely the absence of disease or infirmity” (WHO, 1946). Rohingya refugees living in Bangladesh have experienced many traumatic pre-flight health challenges. They are currently facing some post-flight health challenges at the host country’s refugee camps. These challenges are, in fact, denial or a blow to the components of health alluded to in the WHO definition. The construction of Rohingya health is a crucial area of concern due to the lack of adequate access to medical care at the camp sites that I got through my works based on culture, structure and agency of Culture-Centred Approach. For around one million Rohingyas, there are 175 active healthcare centres in the camp areas. Only 17% of them have 24/7 services (Barua et al., 2022). None of these healthcare centres have intensive care or high dependency unit (ICU/HDU) facilities (Khan et al., 2021b). While the Rohingyas are allowed to access public or private health facilities outside the camp areas, they can do so only after obtaining a referral from a physician. In addition, they also need to obtain permission from the camp authorities for going out of the camps for medical purposes, and to manage the treatment costs. In section 5.2.3 (a) of this thesis, an article titled ““The beggar’s life is better than us”: A culture-centered study in Rohingya refugee camps” discusses various structural barriers faced by the Rohingya refugees in Bangladesh.

When asked to define 'what health meant to them', the Rohingyas participants could not articulate it precisely. Based on the Rohingyas’ agency, for most of them, health is ‘just to live or survive.’ This phrase may be interpreted in different ways. It may allude to the threat and violence they experienced in Myanmar that led them to flee the country, or it may be because they are not allowed to leave the camps for work and sustain on limited food aid. Health may be just survival as they do not see any possibility of changing their stateless

identity anytime soon, nor of improving their conditions including food intake and healthcare which show their overall marginality. Their lives were saved following Myanmar's crackdown in 2017 because the Bangladeshi authorities opened their border. However, in the last six years, the Rohingyas have not seen any positive development in addressing their problems. So, when asked about their health, they were very reluctant to respond or showed frustration. As one respondent observed: "In Bangladesh, even a beggar's life is better than that of ours" (36-year-old Rohingya female). This cynicism is explicable based on CCA as the Rohingyas struggle to survive under the poverty line without any source of income.

Underpinned by Dutta's Culture-Centred Approach, it may be observed that the Rohingyas living in the Bangladeshi camps construct their idea of health in the context of healthcare inaccessibility that is linked to their inability to earn a living. As stated earlier, the Rohingya refugees cannot earn money because the Bangladeshi authorities prohibit them from seeking formal employment outside the camps (Runde, 2023). This prohibition lowers the capacity or agency of Rohingya refugees. Earning plays an important role in obtaining a livelihood and freedom and this, in turn, stabilises the ways in which an individual may conceptualise health (Hughner & Kleine, 2004). As the Rohingya refugees in Bangladesh are not allowed to engage in any formal paid work, their construction of health is significantly impacted by the food aid they receive from international agencies. Due to a recent funding shortfall, food scarcity is widespread in the Rohingya camps of Bangladesh (Ganguly, 2023). This food scarcity has adversely affected the health of the Rohingya refugees. The article titled "Living through food rations: A culture-centered study with Rohingya refugees", included in section 5.2.2 (a) of this thesis, discusses how food scarcity in the refugee camps is directly contributing to the poor health of the Rohingyas.

Based on the historical perspective, it has been observed that Rohingyas had been seeking refuge since 1982. Working on the three triads of CCA, culture, structure and agency, the author reflected that Rohingyas had been living through a continuous refugee life on marginality. The Rohingya participants even perceived that their health is also like a refugee: "In the refugee life, health is also a refugee" (27-year-old Rohingya male). This suggests a sense of disconnection from reality and a high emotional toll on their health and wellbeing. The ways in which the Rohingya refugees living in Bangladesh experience the various aspects of health, including its meaning, have been discussed in further detail in section 5.2.1 (a) titled ""Health Means Just to Live" at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention" and in section 5.2.3 (a) titled, ""The beggar's life is better than us": A culture-centered study in Rohingya refugee camps."

As mentioned earlier, the majority of Rohingyas entered Bangladesh in 2017 and took shelter in the 33 camps of Cox's Bazar. However, since October 2019, these camps were fenced off with barbed wire to prevent the Rohingyas from going out and seeking employment. For their healthcare, the Rohingyas have some primary healthcare centres inside the camps, but the five field hospitals are situated outside. The Rohingyas must carry their ID and face questioning by the APBn police at the camp gates if they need to visit the field hospitals. The refugees now consider their camps like a jail, as one participant observed: "There is APBn police at the camp gate and we cannot go outside without permission. It is just like a jail nowadays as we are not allowed to go anywhere" (20-year-old Rohingya female). Fencing essentially violates Rohingyas' freedom of movement, confines them within the camps, and leaves them at the mercy of APBn police (Fortify Rights, 2020). One Rohingya female observed: "Our entry and exit from the camp depend on the wish of the police guarding at the gate" (22-year-old Rohingya female). Another Rohingya participant was frustrated as he

stated: “By installing fencing, the camp is like a jail” (27-year-old Rohingya male). As the Rohingyas live in a camp fenced with barbed wire, their construction of health depends on and is influenced by the limited and poor healthcare and other facilities available in the camps.

Utilising CCA, I found that the most common obstruction of health communication among the Rohingya refugees in Bangladeshi camps is the language barrier. Most of the physicians and nurses working in the refugee camps come from outside the Chittagong region, who cannot speak or understand the Rohingya language used in communication activities (Zakaria et al., 2022). However, there are no interpreters in any healthcare facility of the refugee camps (TWB, 2022). In the following interview excerpt, a Rohingya majhi explained why they experienced difficulties in expressing their personal health problems to the doctors: “Rohingyas face problems as the doctors/nurses speak in Bengali. At that time, we tried to take a Rohingya person with us who can speak both Bengali and Rohingya language. Sometimes the nurses also help to translate the Rohingya into Bengali. But there is no employed translator/interpreter in the hospital or healthcare centres” (25-year-old Rohingya male).

Health communication always plays an important role in improving the overall health of a marginalised community like the Rohingya refugees. Community Health Workers (CHWs) could play a significant role in this regard as they are recruited mainly from the Rohingya refugee community. More than 1,000 CHWs are providing health information services to the camp inmates, who are considered as the main source of health information (TWB, 2021b). However, my participants observed that they did not receive appropriate service from the CHWs although these health workers provided an excellent service during the Covid-19

pandemic. One female participant said: “During the Covid-19 period they (CHWs) visited us more frequently to talk about the prevention process of Covid-19. They informed us that we should wash our hands with soaps regularly. But after the Covid-19, they do not come regularly to talk to us. Now may be one time in a month or every other month they come to our houses” (23-year-old Rohingya female).

Health communication via mobile phone is an important element of improving public health of the marginalised population (Dmitrieva & Frolov, 2021; Haenssgen et al., 2021). However, Rohingyas have been deprived of the right to get internet and mobile facilities, in both Myanmar and Bangladesh (Hussain & Lee, 2021). Limited or poor mobile connections at the camp area results in poor health outcomes of the Rohingya refugees. Poor mobile phone network at the camp area was mentioned across the interviews. Due to the network problem, the Rohingyas are not even allowed to talk with their relatives living in Myanmar or abroad. One of the participants observed that even during any health emergency they cannot use the mobile phone. She cited: “the mobile network is not good here in the camp. Sometimes there is no network within the camp. We cannot make any video calls with our relatives living abroad; rather we may sometimes talk with them only by mobile through call. Even during any health emergency, we cannot use our mobiles” (42-year-old Rohingya female).

Underpinned by the Culture-Centred Approach, a decolonising framework that works with marginalised communities in understanding the meaning of health constructed at the intersection of structure, culture and agency, the current study explores the construction of health voiced by the Rohingya participants. CCA always tries to develop theories from below by dialogically engaging with the sub-altern community (like the Rohingya refugees),

resisting the Euro-centric top-down health interventions approach (Dutta et al. 2012). In the refugee camps of Bangladesh, the top-down health interventions model has been followed in a way that negatively affects the overall wellbeing of the Rohingyas (IOM, 2019). In the top-down approach, Rohingya participation is totally absent except in the role of end users. While discussing their participation, one Rohingya participant observed: "No NGO or government agencies calls us; rather they take decisions on their own" (27-year-old Rohingya male). This statement clearly demonstrates the top-down mentality of the stakeholders involved in the provision of health services in the Rohingya camps. To form a bottom-up approach, the inclusion of the Rohingya voice is imperative to ensure effective health services for this marginalised community group, which is a basic tenet of the CCA approach and a resistance to top-down health interventions.

If we consider the Rohingya refugee crisis, resulting from systematic state-sponsored atrocities towards a stateless community created by the state (Myanmar) that forced them to flee to Bangladesh, a comment by Arendt (2005) becomes highly pertinent: "once they had left their homeland they remained homeless, once they had left their state they became stateless; once they had been deprived of their human rights, they were rightless, the scum of the earth" (p. 267). Arendt, who was a stateless refugee for eighteen years, observes that the right of a person should be determined by humanity not by citizenship. She stated: "the right to have rights, or the right of every individual to belong to humanity, should be guaranteed by humanity itself" (Arendt, 1951, p. 298). However, the stateless Rohingya community living in Bangladesh or anywhere in the globe without any citizenship document live like they do not have any right to have rights (D' Costa, 2012).

A stateless person is defined by international law as one who "is not considered as a national by any state under the operation of its law" (UNGA, 1954). Rohingyas may be the only community in the globe who became stateless while living within the state even for centuries. Becoming or born through stateless identity, Rohingyas flee from Myanmar and try to take shelters in various countries including neighbouring Bangladesh. Having no legal document of citizenship, the Rohingyas do not even get refugee status in the countries where they try to take shelter. India and Malaysia designate Rohingyas as "illegal immigrants" (Rashid & Saidin, 2023, Sullivan, 2023) and Bangladesh labels them as "forcibly displaced Myanmar nationals" or FDMNs (Faiz et al., 2022). As a result, Rohingyas are deprived of any legal rights including health rights. The problems created by the stateless identity of Rohingyas have been discussed in my article titled, "Statelessness – the Root Cause of the Rohingya Crisis – Needs to Be Addressed" in the Recommendation and Praxis chapter.

While working through CCA, I observed that Rohingya refugees are the recipients of any decisions made by local or international agencies, they do not have the right to say anything about those decisions. Here, Rohingyas are the end users of a top-down approach to decision-making by local and international agencies. Observers mention that "highly top-down approaches have been evident in every sphere of policies and actions" in the camps of Cox's Bazar (Akter et al., 2021, p.12) and it was also evident through the narratives of the Rohingya refugees, observed by me. Utilising the tenets of CCA, I also observed that the Rohingya voices should be considered to take any decision regarding their health and overall wellbeing. If Rohingya voices can be incorporated into the discussion tables, then many of their problems can be articulated and solved as a Rohingya male observed: "I would say that our opinions should be taken into account. We know the best our present circumstances" (64-year-old Rohingya male).

While discussing how the overall health and wellbeing can be ensured with the limited resources available at the Rohingya refugee camps, the participants repeatedly alluded to their identity crisis as an important issue related to all the problems they had been facing. As mentioned earlier, the Bangladeshi government does not recognise them as refugees. Thus, Rohingyas propose to at least grant them the refugee status in Bangladesh: "If we were registered as refugees, then I think our scenario would have been better" (43-year-old Rohingya male). According to the 1951 Refugee Convention, refugees should have access to the same or similar healthcare as host populations (Langlois et al., 2016). This convention has not been followed in the case of the Rohingyas in Bangladesh as they are registered by the host country as FDMN, not as refugees.

A Rohingya female, who was born in Bangladesh and has spent her entire life in the camp, observed: "For our better living in the camp, we need more food ration items, more latrines, good shelters and, if possible, the electricity supply" (23-year-old Rohingya female). Another 24-year-old Rohingya mother of one, who was born in a Bangladeshi refugee camp, demanded that:

> Though we were born here in Bangladesh, we did not get any education opportunity. We demand educational opportunities for our kids. We want our next generation to receive proper education. We believe that without education we will vanish in the future. My earnest request to Bangladesh government is to provide education to our next generation.

The narratives of the Rohingya participants, based on CCA highlighted the need for more health facilities, better shelter, improved sanitation facilities and education for the Rohingya community of Bangladesh to improve their overall health and wellbeing.

The three tenets of Culture-Centred Approach: Culture, structure and agency offer culture-centring social change communication (Dutta, 2020) that is critical to the Rohingya refugees living in the camps of Bangladesh. However, without having an identity or citizenship, a person is not able to practice culture, deprived of social structure, losing agency and it is very much true for Rohingya refugees. The Rohingya community have been stateless since 1982 and the Rohingya children born in Bangladesh, India, Pakistan, Malaysia, Saudi Arabia and elsewhere of the world, are considered as stateless. Rohingyas' statelessness is the pretext of their decade's long sufferings. During my data collection, I met third generation Rohingyas living in the camps without any citizenship and/ or refugee rights. I do believe if the identity crisis of Rohingyas can be resolved then the Rohingya crisis may be solved. So, identity may be considered as one of the doctrines in the Culture-Centred Approach if we think about the Rohingya refugee crisis. Again, in CCA establishment of a local advisory board is fundamental to oversee the research processes, however in case of Rohingyas living in the camps of Bangladesh, it is not feasible as entry is restricted at the camps. Conversely, the Rohingyas living in developed countries, getting a third country resettlement opportunity, may be utilised as a source of data collection to know about the Rohingyas' scenario in Bangladesh or Myanmar, that may be exploited to the world. In summary, I should say the voice of "margins of the margins" Rohingya refugees' should be heard if the world really wants to solve the Rohingya crisis.

Chapter 7: Recommendations and Praxis

7.1 Introduction

The Rohingya refugees have been living in congested, overcrowded, unhealthy bamboo-shelters in Bangladesh since August 2017. More than 700,000 Rohingyas were forced to flee their homeland to save their lives from a brutal military crackdown at that time. The Rohingya situation in Bangladesh has now evolved into a "protracted crisis," with almost a million Rohingya refugees struggling to survive at the camps. The UNHCR has defined a “protracted crisis” or “protracted situation” as one in which at least 25,000 refugees from the same country have been living in exile for more than five consecutive years (UNHCR, 2020d). Local, regional and international actors have made some effort to resolve the Rohingya crisis, but with no tangible positive outcome so far. The crisis has been continuing for decades. Bangladesh continues to consider ‘repatriation’ as the only viable resolution for the Rohingya crisis, though not a single Rohingya has been repatriated to Myanmar since 2017. In 2018 and 2019, the two neighbours made two efforts towards Rohingya repatriation, but both the initiatives failed. Currently, a third effort is underway (Rahman, 2023c). The repatriation efforts have failed as the Rohingyas refuse to return to Myanmar unless their rights, especially their citizenship status, are ensured.

As the protracted crisis lingers, the Rohingya refugees in Bangladesh continue to face a grim situation adversely affecting all aspects of their life including health. The current study contributes to an understanding of the meanings of health among the Rohingyas and how their health scenario can be improved with available resources and existing facilities. In this

chapter, some recommendations to improve the overall health of the Rohingyas will be discussed.

7.2 Rohingya funding should be continued

The Rohingya refugees of Bangladesh are entirely dependent on aid, as they are not allowed to work and do not have access to any land in the camps to grow food. However, the international aid for the Rohingya refugees in Bangladesh has declined gradually over the years, creating a burden for the host country in managing the protracted situation. Through the 2023 Joint Response Plan (JRP), the UN Refugee Agency and its partners appealed to donors for $876 million to the donors, but up to September 2023, only around 30% of the fund could be obtained (Sakib, 2023a). There is always a shortfall in the JRP proposed funding, which has grown yearly. In 2021, the funding shortfall was 28%; in 2022 the shortfall was 37%; and in 2023, the shortfall is likely to be 70%. As the Rohingya crisis is now under a protracted situation, more funding is required to meet the basic health needs of the Rohingya refugees in Bangladesh.

Citing a $125 million funding shortfall in 2023, the World Food Programme (WFP) slashed the food ration for the Rohingyas twice, from $12 USD to $8 USD per person per month. For the Rohingyas residing in the camps, who are barred from any paid employment, food assistance from the WFP is a key pecuniary resource, and important for their livelihood (Porter, 2023). For this reason, the food ration cuts of over 30% by the WFP in just three months, have had detrimental effects on the Rohingyas' health and wellbeing. There is already a high level of malnutrition among the Rohingya children in Bangladesh. The current

cuts in food aid will put them in an even more vulnerable situation. The WFP, in a report in October 2023, has observed that, after the start of food ration cuts in March 2023, there are increasing malnutrition trends among the Rohingya children (WFP, 2023c). The report mentioned that based on Mid-Upper Arm Circumference (MUAC) screening, the acute malnutrition rate among the Rohingya children is 3.4% in 2023, around double the rate of 1.8% in 2022. There is a possibility that an entire generation of Rohingya children might experience stunted growth as a result of the food ration cuts (Jegan, 2023).

The value of food rations provided to each Rohingya refugee is now $8 per month, or 27 cents per day. In other words, it amounts to nine cents or around 10 Bangladeshi taka per meal. Some observers questioned whether it was justified to think that 10 Bangladeshi taka per meal was sufficient for the Rohingyas where just one egg costs more than 12 taka in local Bangladeshi markets (Hennessey et al., 2021; Nabi, 2023). Before the second food ration cut of June 2023, each Rohingya individual used to receive two bars of bathing soap each month. Now the authorities have reduced this allocation to one bar of soap per person (NGO Platform, 2023). Skin diseases, such as scabies, are on the rise in the Rohingya camps, and the recent cut in soap ration risks a further increase in skin diseases. Because of a significant reduction in food assistance, the Rohingya refugees might be forced to take desperate measures, including getting into child marriage and embarking on dangerous boat journeys by sea (UNHCR, 2023b). Early marriage is a common cultural practice in the Rohingya community, and the food ration cuts may force them to continue with child marriages and even resort to prostitution (Kamruzzaman, 2023).

The food ration cuts put Rohingya women and children, who make up more than 75% of the Rohingya population, in an extremely difficult situation. Some humanitarian agencies warned

that there was a possibility of a higher risk of abuse, exploitation, and gender-based violence against them. Within this group, the babies (0-59 months) and pregnant mothers, both highlighted as 'prioritised sector objectives' by the Office for the Coordination of Humanitarian Affairs (OCHA) will face the most critical scenario due to the ration cuts (Regan, 2023). Even before the ration cuts, MSF reported that "12% of pregnant women at Kutupalong hospital and Balukhali clinic were diagnosed with acute malnutrition and 30% with anaemia" (MSF, 2023a). MSF also observed that women who were malnourished or anaemic were more likely to experience "complications during childbirth", while their new-born children were predicted to suffer from "poor health outcomes" (Regan, 2023). Earlier, the $12 food ration could not fulfil the food needs of the Rohingyas; now with the $8 allocation, a healthy meal has turned into a pipe dream for them.

Some observers think that funding for the Rohingyas has been dropped due to crises in other parts of the world, including Afghanistan and Ukraine. Indeed, the funding for Rohingyas had started to dwindle further after the onset of the COVID-19 pandemic due to global economic constraints following the pandemic (Jamshed, 2021). However, the funding had begun to reach critical levels last year i.e., in 2023. Along with the COVID pandemic, the Afghanistan crisis and Ukraine war have resulted in the slashing of funding for the Rohingyas. Western countries' preoccupation with the Ukraine war put the Global South's Rohingya crisis to the backstage, resulting in reduced funding (Yamada, 2023). There is a risk that the Rohingya funding will decrease further in the coming days. Each Rohingya individual currently receives $8 food aid per month. The amount may become $6 or less per Rohingya if the WFP fails to receive adequate funding (Tan & Faruque, 2023).

The Centre for Policy Dialogue (CPD), a Bangladeshi think tank, observed that Bangladesh had to spend around $1.22 billion yearly to manage the Rohingya crisis (Jamshed, 2021). The country has already spent more than US $90 million to install barbed-wire fences around the camps and US $380.31 million for the Bhasan Char project (Rahman, 2023d). Bangladesh, along with its international partners, has been hosting the Rohingya communities for decades. However, after six years, the Rohingya crisis no longer seems to be considered an emergency by many countries, though it is still a humanitarian emergency. So, the Rohingya crisis should not become a forgotten crisis; rather continued funding and support need to be ensured to meet the basic needs of the Rohingyas.

7.3 Gap between the Rohingyas and the locals need to be addressed

The huge number of Rohingyas arriving in 2017 were welcomed by the local communities of the Ukhiya and Teknaf upazilas of Cox's Bazar district. Even before the Bangladesh government agencies could engage with the Rohingyas, the local people mobilised various resources to ameliorate the sufferings of the Rohingya refugees (Ansar & Khaled, 2021). However, this sympathetic attitude towards the Rohingyas has declined significantly over the past six years. With the recent arrival of the Rohingyas, the demography of the Ukhiya and Teknaf upazilas has changed, with the Rohingya population around three times greater than that of the locals (Habib & Chowdhury, 2023). After the 2017 crisis, Bangladesh and international agencies allotted 75% of allocated assistance to the Rohingya refugees and 25% to the locals, which created some disparities with the host communities. The dissatisfaction among local people near the Rohingya camps amounts to 30.17%; they are unhappy as their neighbourhood has turned overcrowded, polluted, unsafe, and insecure (Biswas et al., 2021).

The locals perceived several challenges with the huge Rohingya influx in 2017. Agricultural lands were damaged as the refugee settlements and humanitarian agencies occupy many croplands, thus adversely affecting the locals (Sattar, 2019). Living expenses have increased in the Cox's Bazar area due to the presence of the Rohingya community and the increased activities of international agencies. Alam et al. (2022) observed that there was an overall 8% increase in food prices in the Ukhiya upazila where most of the Rohingyas live. As the prospect of Rohingya repatriation from Bangladesh seems to be a distant hope, social cohesion between the Rohingya and the locals has become more complex than ever. The 2021 military coup in Myanmar made the prospect of repatriation more uncertain. Consequently, the host community perceive that the Rohingyas may stay in Bangladesh for much longer than they anticipated.

During my stay in Ukhiya upazila and Cox's Bazar town, I talked with many locals about the situation in their localities. Many expressed their anger openly against the Rohingyas living in their area. While visiting the Inani[20] beach in December 2021, I hired an autorickshaw, locally known as Tom-Tom, for a day. I spoke with the Tom-Tom driver, a local, who said that they faced many challenges after the Rohingya arrival in Cox's Bazar. He observed that the prices of goods in local markets were higher than before, and the house rent had increased. He asked whether I had any idea when the Rohingyas would leave Bangladesh. During my 19-day stay in Ukhiya, I also visited the homes of various local people and tried to find out about their attitudes towards the Rohingya crisis. The locals expressed their deep frustration as the promised repatriation had not yet started. They had expected that the Rohingyas would leave their land immediately.

[20] Inani beach is a sea beach situated in Ukhia Upazila of Cox's Bazar District; this beach is about 18 kilometres long. This beach has grey sands, and it is special for its rock and coral boulders. (Ahmed et al., 2014)

It is evident from the above perspectives that some tensions exist between the Rohingyas and locals regarding access to livelihoods. Though the Bangladeshi government fenced off the Rohingya camps with barbed wire, the Rohingyas try to cross these fences by any means, including bribing the security personnel to go out and search for work in nearby areas (Sullivan, 2022). This engenders a conflict of interest between the Rohingyas and the host communities as they compete for limited available jobs. Macdonald et al. (2023) found that 70% of the locals around the Rohingya camps viewed their life as worse since the arrival of the Rohingyas. Though the views of the Rohingya community towards the local community are very positive, the host community's views have transformed from "solidarity to resistance" towards the Rohingyas (Ansar & Khaled, 2021). Some observers feel that it is urgent to address the tensions between the Rohingyas and the locals of Cox's Bazar. The Joint Response Plan (JRP), which has stressed the importance of protecting and supporting both the Rohingya and host communities since 2018, advocates for further strengthening of social cohesion between these two communities.

Bangladeshi political leaders have made it clear that they did not want the Rohingyas to stay in Bangladesh for an extended period. The authorities have cut off Rohingyas' access to the rest of the country and confined them to the camps (Riley, 2022). The local community leaders of Cox's Bazar also expressed a strong opinion against allowing the Rohingyas to work. The locals try to isolate the Rohingyas by spreading anti-Rohingya rhetoric around Cox's Bazar. Some of this rhetoric against the Rohingyas is xenophobic and it is spreading rapidly not only in Cox's Bazar but throughout Bangladesh. A recent study of 200 university graduates in Bangladesh found that 85% of the respondents noticed that the term "Rohingya" was being used as a means of bullying in the host country (Hossain, 2023b). The current refugee population accounts for one-third of the total population in the Cox's Bazar region,

which puts pressure on the overall living standards of the host community (UNHCR, 2023a). In these circumstances, building up social cohesion between the locals and Rohingyas is urgent to prevent simmering tensions from turning to serious social divisions or violence.

7.4 Voice of Rohingyas needs to be heard

The Rohingyas are still facing a profound "othering." Their voices have not been heard at any level of the decision-making processes which affect them, despite the fact that some of them have been living in Bangladesh since 1977 (Lough et al., 2021). The opinions of the Rohingyas have not been sought on important matters affecting their lives, such as their repatriation, relocation, or various activities in the camps (Sullivan, 2020). There are instances in which good results could be obtained by engaging the Rohingyas in the decision-making processes, but the Rohingyas are systematically ignored. A case in point is that the Rohingyas were involved in the food distribution in the camps in 2002. By engaging the Rohingyas in food distribution, some good outcomes were achieved and the Rohingyas were satisfied with the service (MSF, 2002). At that time, the MSF food aid was distributed by the Bangladesh Red Crescent Society (BDRCS), that hired local people to do the job. However, getting complaints from the Rohingya refugees regarding distribution, the BDRCS replaced the locals with Rohingyas. As a result, the refugees received the accurate amount of food aid allocated to them. This incident makes it evident that refugee engagement results in positive outcomes. However, the Rohingyas are not generally involved in any tasks except some jobs related to camp infrastructure development.

During my last field visit to the Rohingya refugee camps in 2020-2021, I repeatedly asked the refugees for their opinion about how their overall situation could be improved. Most of the participants (40 out of 41 participants) demanded their children's education because they viewed that it was the best way of improving their circumstances in the long run. A Rohingya female observed, "My only demand is to ensure education for our kids." When asked about their participation in any decision-making process, the majority (39 out of 41) replied that they were not involved in any decision-making processes whatsoever. When I asked why nobody sought their opinions, they replied that the Bangladeshi government or the international agencies consider them uneducated. A senior Rohingya male, who worked as a teacher at a Learning Centre (LC), said,

> No opinion of us is generally sought by any agency. They made the decisions based on their own judgement. They think that we are uneducated, so they do not ask us anything. But as a schoolteacher, I would say that our opinions should be taken into account. We know the best our present circumstances. (64-year-old Rohingya male)

In Bangladesh, the Rohingya refugees can express their opinions when any local/international delegates or foreign envoys visit the camps. However, the Rohingyas were not permitted to do so while they were in Myanmar (MacDiarmid, 2018). When delegates leave the Rohingya camps of Bangladesh, they usually make various promises, but nothing much has happened in the past six years to solve the Rohingya crisis. Many Rohingyas observed that they had given up on pleading for more Western aid or even on solving the decades-long crisis. The two repatriation efforts undertaken in 2018 and 2019 had failed because the concerns or voices of the Rohingyas were not taken into consideration (Crisis Group, 2023). In 2023, a pilot repatriation deal was struck between Bangladesh and Myanmar, which was backed by China. Under this deal, some Rohingyas were taken to the Rakhine state of Myanmar on a

visit to see the overall conditions there. Upon their return, the Rohingyas stated that they would not go back to Myanmar as they would not be resettled in their villages, and their citizenship rights would not be ensured (Rahman & Chowdhury, 2023). So, it can be said that if the international community really wants to solve the Rohingya crisis, the voices of the marginalised Rohingyas need to be heard.

7.5 All possible durable solutions should be considered

By the end of 2022, the world had around 35 million refugees. Humanitarian agencies aim for one of three durable solutions for them: voluntary repatriation, local integration, and resettlement (Dönmez, 2023). Of these, the voluntary repatriation of refugees to their home countries has been considered the best possible solution to any refugee crisis. Though the Rohingya crisis is now in a "protracted situation," Bangladesh still considers repatriation the only viable solution to this prolonged crisis. The Bangladeshi authorities made some attempts in the last six years to repatriate the Rohingyas, but none could be returned to Myanmar so far. Following the failed repatriation attempts in 2018 and 2019, Bangladesh started to work on a pilot project in 2023 to commence the repatriation process. The present junta government of Myanmar agreed to take back around 1,100 Rohingyas under this pilot project. However, some observers doubt the junta's sincerity in this process. They fear that the agreement might be a tactic to relieve the Myanmar army government of international pressures or legitimise the military rulers (Rasid, 2023).

Local integration is the process by which refugees can enjoy rights like those enjoyed by the host country's citizens. However, the Bangladeshi authorities do not allow any measures that promote Rohingya integration into the local society. In other words, Bangladesh's official

position is that it will not entertain any notion of local integration of the Rohingyas. The Bangladeshi authorities have also taken various measures to limit the number of Rohingyas to be integrated into the host society. For example, intermarriage between the Rohingyas and local Bengalis has been prohibited since 2014; Rohingya children born in Bangladesh do not have any access to birth registration; and Bangla language education is prohibited in the refugee camps (Xchange, 2018). Bangladesh is a densely populated country with 165 million people living in an area of 148,460 square kilometres (BBC, 2023). The Bangladeshi authorities are of the view that this country is unable to integrate the Rohingyas due to its high population and limited resources.

Despite Bangladesh's measures to limit any integration, the Rohingyas have been integrated into the local society for decades (HRW, 2000). The Rohingyas easily intermingle with the host community, especially with the Chittagonian society, because of their religious, cultural and linguistic similarities to local communities (Sajjad, 2020; Talukder, 2023). As Rohingyas have been living in Bangladesh since the 1970s, they try to integrate into the Bangladeshi society; and have succeeded at times. Rohingya integration is achieved in mainly two ways: i) illegally obtaining official Bangladeshi nationality documents, and ii) intermarriage with Bangladeshi nationals (Rahman et al., 2021). There are reports that 250,000 Rohingyas have travelled overseas using Bangladeshi passports (Mahmud, 2018; Mostofa, 2020). Furthermore, intermarriage between the Rohingyas and Bangladeshi citizens has been continuing, especially between Bangladeshi men and Rohingya women, despite an official ban on it (Sakib, 2023b).

Third-country resettlement is the transfer of refugees from an asylum country to another state that has agreed to admit the refugees and ultimately grant them permanent residence. It is also

known as permanent asylum in a third country (Ragland, 1994). Third-country resettlement is the best option for those refugees who cannot be repatriated or integrated into the host country. From 2006 to 2010, approximately 920 Rohingyas from Bangladesh have been resettled in other countries, such as Australia, New Zealand, Canada, and the United States (Paul & Das, 2020). From 2010, the Bangladeshi government did not allow any third-country resettlement for the Rohingyas stating it may work as a pull factor for more Rohingyas from Myanmar (Mithun, 2023). However, Bangladesh has recently agreed to allow the third-country resettlement of the Rohingyas as the crisis entered a protracted phase. In 2022, the USA announced that it would take 62 Rohingyas every year through a third-country resettlement process (BSS, 2022). Since 2009, the USA has received 13,000 Rohingya refugees from various countries (US Embassy BD, 2023).

As Bangladesh is now agreeing to third-country resettlement of the Rohingyas, other refugee-recipient countries should also come forward. Australia, under its special humanitarian program, has provided visas to 470 Rohingyas since 2008, which is a very small number (Ware & Kironska, 2023). In New Zealand, an estimated 1,500 Rohingyas have been resettled since 2005 (Rahman & Dutta, 2023). Australia and New Zealand received those Rohingya refugees mainly from Malaysia, Thailand, and Indonesia. Refugee advocates think that now it is time for these countries to receive more Rohingyas from Bangladesh. Like Australia and New Zealand, other developed countries, such as Canada, Japan, Norway, Russia, and other European states should show their willingness to take Rohingyas from Bangladesh (Runde, 2023). Bangladesh has been providing refuge to the Rohingyas for decades, and has hosted around one million Rohingyas in the camps, with 30,000 Rohingya children born each year. The advocates think that now it’s time for developed nations to translate their promises into actual deeds.

Third-country resettlement and/or local integration can absorb only a small number of Rohingyas. For example, from 2003 to 2021, Malaysia could send only 8,312 Rohingya refugees to third countries for resettlement (Shariff et al., 2022). Thus, the repatriation of a massive number of Rohingyas from Bangladesh to Myanmar is the only viable solution to the prolonged crisis. The Myanmar authorities have shown some interest in Rohingya repatriation, although their intention is not without doubt. Nevertheless, for the safe repatriation of Rohingyas from Bangladesh, the negotiators should consider not only the Myanmar Army, which is now in state power, but also other actors, such as the Arakan Army (AA) which in fact controls the Rakhine state. Rakhine is Rohingyas' place of origin. Thus, the current players in Rakhine, such as the Tatmadaw, the AA, the Rohingya and Rakhine community leaders, political parties, civil society organisations, and other stakeholders should be involved in making the Rohingya repatriation deal a success (Hasan, 2023). I wrote an article, titled "Rohingya repatriation: Various actors need to be considered," in which I discussed the actors to be involved in Rohingya repatriation.

Link Six

A part of chapter 7 [7.5(a)] titled, “Rohingya repatriation: Various actors need to be considered” was published on 17 August 2022, by Refugee Research Online, an online platform for academic and non-academic research, and comment on issues surrounding people seeking asylum and refugees.

The article examines the various contemporary actors who need to be involved in any attempt at Rohingya repatriation. It describes the recommendations to count on the actors from the Rakhine state so that the Rohingyas become confident to return to their birthplace. In this article, I argue that the Arakan Army (AA), which is the current controlling authority of Rakhine, should be involved as a stakeholder of Rohingya repatriation. Both of my supervisors, Professor Mohan Dutta and Dr. Akhteruz Zaman, provided feedback on the draft of the article.

7.5 (a) Rohingya repatriation: Various actors need to be considered

(A published online article)

Rahman, M. M. (2022, August 17). Rohingya repatriation: Various actors need to be considered. *Refugee Research Online*. https://refugeeresearchonline.org/rohingya-repatriation-various-actors-need-to-be-considered/.

Bangladesh is trying to resolve the burden of the Rohingya crisis by repatriating the Rohingyas to Myanmar who have been staying in Bangladesh for decades. Bangladesh has also agreed to the voluntary, safe, dignified, and sustainable repatriation of Rohingyas without refoulement. After the crisis of 2017, Bangladesh made an agreement with the Myanmar government in November 2017 and then took part in meetings with Myanmar government representatives, China and other international mediators to start the repatriation process. However, five years later not a single Rohingya has been repatriated to Myanmar. Still, more than 1.3 million Rohingyas have been living in Bangladesh for this time and most of them staying in the 33 makeshift camps in Cox's Bazar.

From 2017 to 2020 only the Myanmar government of Suu Kyi backed by the military [Tatmadaw], was considered responsible for the Rohingya repatriation process. But from the beginning of 2021 another powerful party, the Arakan Army [AA], an ethnic armed organisation from Rakhine state, emerged and now controls the majority of Rakhine state. Now the question is who is the main actor in the repatriation process of Rohingyas from Bangladesh: the Tatmadaw (the current Junta government) or the AA (the current Rakhine government)? If the current Junta government agreed to repatriate Rohingyas from Bangladesh how would this succeed without approved consent from the AA? If the NUG

(National Unity Government), an anti-Junta shadow government formed in April 2021, returns to power, what will their position be regarding Rohingya repatriation?

Rakhine: The birthplace of the Rohingya

The Rohingya, an ethnic religious minority group, the majority of whom are Muslims, have lived in the Rakhine state of Myanmar from time immemorial. Before the 2017 exodus there were over one million Rohingyas residing in Rakhine who were without citizenship. After the independence of Myanmar in 1948, the Rohingya people started to lose their rights and after 1982 with the enactment of apartheid like citizenship laws they became stateless. Since 1962 the Rohingyas were the target of the Tatmadaw, and the Army authority always tried to expel the Rohingyas from Myanmar through their discriminatory policies. In 2017 under the brutal tactics of the Tatmadaw, more than 90% of Rohingyas were forced to leave their motherland, Myanmar.

The Arakan Army: The controlling authority of Rakhine

Rakhine (formerly known as Arakan) was conquered and colonized by various powers since the arrival of Kongbaung dynasty in 1785. Burmese King Boddawphaya invaded the Arakan (Rakhine) in 1785 and at that time some 35,000 Arakan Muslims (Rohingya) were forced to leave Rakhine state. This was the first exodus of Rohingya towards Bengal. The Rakhine state was then controlled by external forces including Britain (1824 – 1942), Japan (1942 – 1945), and Britain a second time (1945 – 1948). In 1948 Myanmar gained its independence. Following independence, Rakhine was under the control of the Civilian Government (1948-

1962), the Military Government (1962-2015), and the Suu Kyi Government (2016-2021). The Myanmar Army or Tatmadaw took power through a coup on 1 February 2021 but even before this, the control of Rakhine state had begun to fall under the control of the AA-ULA [Arakan Army – United League of Arakan] particularly after a ceasefire agreement in December 2020.

Recent reports suggest that the Rakhine government is now run by the de facto AA-ULA government structure. Civilian works have been performed by the AA's administrative branch, known as the Arakan People's Authority [APA]. The APA has its own specialized judicial, police and tax system. In two interviews given to the Bangladesh daily newspaper the Prothom Alo and the Hong-Kong based Asia Times in January 2022, the AA's leader, General Twan Mrat Naing, discussed the group's position in Rakhine state and he also gave his views on the ongoing Rohingya crisis. In the interviews, General Naing stated he advocated the ULA-AA's objective of achieving internal sovereignty in the short term while maintaining the long-term goal of independence.

The AA and NUG

The NUG, the shadow government of Myanmar formed by lawmakers elected in the annulled 2020 polls showed positive sentiment towards the Rohingya minority, recognizing the discrimination and human rights abuses against them. The NUG was the first political organization of Myanmar which, after 1962, recognized the Rohingya as a specific ethnicity. Though the NUG's main aim is to overthrow the military junta, their recognition of Rohingya identity may help the ethnic group to recognise and establish their rights. However,

analysts observe that even if the NUG can obtain power by defeating the Tatmadaw, the AA will still be the most powerful actor in Rakhine state.

Rohingya repatriation – who is the main actor in Myanmar?

As state power is in the hands of the Tatmadaw, the main actor for the Rohingya repatriation will undoubtedly be the military junta. But, as Rakhine is under the control of the AA, they can play an important role in the repatriation process of Rohingyas. Bangladesh has still not entered formal talks with the AA but there are proposals from various ends that Bangladesh should start negotiations with the ULA-AA to work towards the repatriation of Rohingyas who are still waiting to return. During the interview, the AA leader acknowledged that the issues facing the 'Rohingya' were 'a fundamental question of human rights.'

The NUG has indicated a pro-repatriation stance and the majority of Myanmar people who once supported negative narratives about the Rohingya have now revealed some sympathy four years after the massacres against them. The AA has also showed its intention to work for the welfare of all the ethnic groups including the Rohingya Muslims in Rakhine state. Though the AA and Tatmadaw have maintained a ceasefire since the end of 2020, the situation may change at any time. So, an intensive diplomatic effort from international organizations is needed so that Rohingya refugees can return to their motherland before the peaceful situation in Rakhine state deteriorates. The Crisis Group in its June 2022 report titled 'Avoiding a Return to War in Myanmar's Rakhine State,' also suggests that Naypyitaw and Dhaka should open dialogue with the Arakan Army on Rohingya repatriation.

7.6 Citizenship rights should be ensured 'first and foremost'

Despite living in Myanmar for generations, the Rohingya community have been deprived of citizenship rights since 1982. The military-drafted Citizenship Act of 1982 is the legal instrument of Myanmar government behind Rohingyas' statelessness (Chickera, 2021). Following this forceful stripping of citizenship from the Rohingyas, the Myanmar authorities undertook a series of persecutions and violence against them which resulted in forced migration. Since Myanmar stripped the Rohingyas from citizenship, the persecuted people have no legal rights, even with refugee status in most of the countries where they took refuge. The Rakhine Advisory Commission, headed by the late former UN Secretary-General Kofi Annan, also observed in its 63-page fact finding report that the biggest obstacle to establishing peace in Rakhine state is the issue of citizenship (Shams, 2017). So, my observations argue that granting citizenship to the Rohingyas is the answer if the world really wishes to solve the decades-long Rohingya crisis.

Link Seven

A part of chapter 7 [7.6 (a)] titled, “Statelessness – the Root Cause of the Rohingya crisis – Needs to Be Addressed” has been accepted by a think tank organisation of the USA, named New Lines Institute for Strategy and Policy.

This article has been written based on the findings of my fieldwork and pilot study at the Rohingya refugee camps of Bangladesh and some excerpts from the interviews of Rohingyas living in New Zealand under the UNHCR’s third-country resettlement program. Based on Dutta’s CCA, a decolonising framework, this article describes the recommendations to solve the Rohingya crisis mainly based on citizenship rights. The author believes that resolving the issue of Rohingya statelessness can lead to a possible end to the Rohingya crisis. Both of my supervisors, Professor Mohan Dutta and Dr. Akhteruz Zaman, provided feedback on the draft of the article.

7.6 (a) Statelessness – the Root Cause of the Rohingya Crisis – Needs to Be Addressed

(An accepted article)

Rahman, M. M. (2023) (Accepted). Statelessness – the Root Cause of the Rohingya Crisis – Needs to Be Addressed. ***New Lines Institute for Strategy and Policy, USA.***

Executive Summary

Rohingyas, who make up the "world's largest stateless population" of more than 3.5 million, are an ethno-religious minority group originating in Myanmar. Although the ancestors of the Rohingyas and their ancestors have been living in northern Rakhine state since the 8th century, Myanmar does not recognize their citizenship rights. Government-sponsored discrimination, detention, abuse, violence, and torture have been unleashed against them. In Myanmar, Rohingyas do not seem to have the right to have rights. The country's military government enacted the apartheid-like Citizenship Act in 1982, which made the Rohingyas stateless. They fled persecutions to various countries, including neighboring Bangladesh, India, Pakistan, Thailand, Saudi Arabia, the United Arab Emirates, Malaysia, Indonesia, and Australia. After the recent genocide of August 2017, only 600,000 out of the total Rohingya population is left in Myanmar. The rest are dispersed around the world as stateless people. Currently, the highest number of Rohingyas — more than 1.6 million — live in Bangladesh. Among them about million are sheltering at the 33 camps of Cox's Bazar, the South-Eastern district of the country, and thousands live in Bhasan Char, an island at the Bay of Bengal. In the refuge countries including Bangladesh, Rohingyas are denied basic rights and protection because of their statelessness. Intense and continued diplomatic efforts from international organizations — such as the United Nations, European Union, Organization of Islamic

Cooperation (OIC), Association of Southeast Asian Nations (ASEAN) — and regional powers, including China and India, are essential for solving the decades-long Rohingya crisis. A crucial point in resolving the crisis should have been to ensure an end to the Rohingyas' stateless identity.

Introduction

Myanmar (formerly known as Burma) is a South Asian country surrounded by Thailand, Laos, China, India, and Bangladesh (Htun et al., 2011). Its population includes various ethnic communities, such as the Karen, Shan, Mon, Chin, Kachin, Rakhine, and Karenni people. The country's Constitution divides Myanmar into seven ethnic states (Martin, 2021) and recognizes 135 distinct ethnic groups (Cheesman, 2015). However, the Rohingyas have not been included in this list. Consequently, they have been stripped of their citizenship rights, despite living in the Rakhine state for centuries, and have been rendered stateless (Chaturvedi, 2012; Ibrahim, 2016; Rahman, 2023a). The latest census, in 2014, which reported that Myanmar had a population of more than 51.4 million, excluded the Rohingyas (McLaughlin, 2015). Many believe that more than 1.1 million Rohingyas lived in Myanmar at the time of the census (Ferguson, 2015; Leider, 2018). But the authorities refused to count them as "Rohingyas"; instead, they used the terms "Bengalis" or "foreigners" to label them (IRIN, 2014).

The Rakhine state of Myanmar is one of the poorest among the country's seven states (Burke, 2016; Smith, 2019). The state was known as "Arakan" until 1989 (Leider, 2018). The entire country changed its name from "Burma" to "Myanmar", also in 1989 (Chan, 2005; Faye,

2021). In Rakhine state, apart from a few hundred Hindus and Christians, the vast majority of Rohingyas are Muslims, and they constitute 4% of Rakhine's population (Ahmed et al., 2021). The Rohingyas constituted 1% of the total population of Myanmar, and 45% of the country's total Muslim population (Chan, 2017; Habibollahi, McLean, & Diker, 2013). However, this estimate was made before 2017, when the military government perpetuated a massacre against the Rohingyas and expelled about 90% of them from the country (Ibrahim, 2018; Furcoi, 2018; Wells, 2019). Rohingyas are Muslims, but Buddhism is the state religion of Myanmar, and almost 90% of the population practices Theravada Buddhism (Fulton, 2022; HRW, 2009). Lynn (2016) observed that in the last 35 years the total Muslim population of Myanmar decreased to 2.3% from 3.9% (excluding Rohingyas). This decrease can be contrasted with the Islamophobic claim of Myanmar's leaders that the Muslim population of Myanmar may make the majority (Juergensmeyer, 2017).

Following Myanmar's independence from Britain in 1948, the civilian governments recognized Rohingyas as citizens and issued them identity cards as Burmese citizens (Poling, 2014; Rahman & Mohajan, 2019). This recognition continued until 1962, when the military took political power and started to curtail the Rohingyas' citizenship rights (Ali, 2021; Selth, 2018). The military junta suspended the 1947 Constitution and introduced a new one in 1974. Following this new Constitution, the military authorities disqualified many Rohingyas as Burmese citizens (Hung, 2021). The authorities then enacted the 1982 Citizenship Act, which completely denied the Rohingyas' citizenship rights (Alam, 2015; Brinham, 2019). Since 1982, the Rohingya communities have been living in Myanmar but have been denied the "right to have rights" (Christopher & Schiffer, 2019; D' Costa, 2012). Thus, the long history of discrimination, persecution, and violence against the Rohingyas began in 1962, and these stateless people are still suffering this misery.

Literature Review

A stateless person may be defined as one not having a nationality from any country. In other words, no country recognizes the person as belonging to it. According to Article 1 of the 1954 Convention on Statelessness, this term means, "not considered as a national by any state under the operation of its law" (UNHCR, 2021c). The exact number of stateless people in the world is unknown, but the United Nations High Commissioner for Refugees (UNHCR) estimates that this figure is more than 10 million (Refugee Council Australia, 2021). However, according to a recent document (U.N. News, 2022), so far, the UNHCR has managed to count only 4.3 million people as stateless. Of them, the Rohingyas constitute the largest group (Vaidyanathan, 2022). The total Rohingya population is more than 3.5 million, but the majority is stateless and is scattered around the world (Hossain & Hosain, 2019; Rahman & Dutta, 2023). The highest number of stateless Rohingyas currently live in Bangladeshi camps, since their expulsion from Rakhine (Rahman, 2022a; Uddin, 2023). However, the Bangladeshi authorities do not recognize these Rohingyas as refugees; instead, they label these displaced people as Forcibly Displaced Myanmar Nationals, or FDMNs (Faiz et al., 2022; Rahman, Mohajan, & Bose, 2021).

Many critics have observed that the Rohingyas' marginalization and persecution stem from their statelessness (Rhoads, 2022). Chickera (2021), Debnath, Chatterjee, & Afzal, (2022), and Eisenman (2017) observed that the Myanmar government expeditiously stripped the Rohingyas of their nationality and forced the condition of statelessness on them. Caster (2016) noted that without any citizenship rights, the Rohingyas were also deprived of their human rights, including education, healthcare, and freedom of movement in Myanmar. The Myanmar government's "Operation Dragon" (Naga Min) program, designed to check the

Rohingyas' citizenship registration cards, prompted the first expulsion of Rohingyas in 1978 (Chen, 2016). The next two influxes (in 1991-92 and 2012), during which a significant number of Rohingyas fled to Bangladesh, were the consequences of the 1982 Citizenship Act (Kaveri & Rajon, 2023). The largest human exodus in Asia since the Vietnam War occurred in August 2017, when the Rohingyas fled in droves to Bangladesh (Desale, 2020; Rahman & Sakib, 2021). This incident was also the consequences of Rohingya statelessness. The Time magazine journalist Feliz Solomon termed it the "exodus of the stateless" (Solomon, 2017).

The stateless Rohingya refugees do not have any identity or legal documents. This lack of documentation makes them susceptible to discrimination (Gonzalez, 2019). For example, confiscation of land belonging to the Rohingyas has been widespread in Rakhine since the 1990s. Until today, many members of the Myanmar armed forces have occupied Rohingya lands without any compensation (Forino, Meding, & Johnson, 2017; Minority Rights Group International, 2017). When a Rohingya individual loses lands in Myanmar, he or she becomes "'homeless'" in addition to being 'stateless'" (Milton et al., 2017). The Rohingyas, who do not have citizenship rights, also do not have access to education, health care, or employment, and they are unable to participate in the political process (Sudheer & Banerjee, 2021). Kaufman (2016) and Lewa (2012) observed that more than 60% of Rohingya children between the age of 5 and 17 years have never been enrolled in any school in Myanmar. The illiteracy rate among Rohingya children is nearly 80%, as they are excluded from accessing formal education (Carroll, 2021). So the Rohingyas continue to flee their country in the face of this deprivation of their rights and state-sponsored persecutions and violence. However, the countries where they take shelter — for example, Bangladesh, Malaysia, Indonesia, India, and Pakistan — do not recognize the Rohingyas as refugees due to their stateless status (Brunt, 2017; Rahman & Dutta, 2023).

The Stages of Rohingya Statelessness

The authorities in Myanmar accepted the Rohingyas as a separate indigenous ethnic group immediately after the country's independence in 1948. The Rohingyas then enjoyed all rights as citizens (Mithun, 2018). However, the Rohingyas' miseries ensued after the military takeover in the 1960s (Selth, 2018). Over the years, military governments have created, pursued, and implemented various discriminatory policies to legally exclude the Rohingyas from their citizenship rights (Kaveri & Rajon, 2023). The Rohingya political activist Nay San Lwin noted that "Rohingya statelessness is not an accident of history, it was deliberately produced by the Myanmar military" (quoted by ISI, 2020, p. 2).

From 1948 to 1962: Civil Administration – Full Citizenship for Rohingyas

Myanmar achieved its independence following an agreement, signed on October 17, 1947, between British Prime Minister Clement Attlee and Burmese Constituent Assembly President Thakin Nu (Aung, 2019). Article 3 of the Nu-Attlee Agreement identified Rohingyas as bona fide citizens of Myanmar (EFSAS, 2018). In independent Myanmar, individuals were not required to belong to an officially recognized race to be a citizen. Thus, the Rohingyas were considered citizens (Farris, 2017). The first prime minister of Myanmar, U Nu, granted special area status, titled "Mayu Frontier Administration (MFA)," to northern Arakan, where the Rohingyas were dominant (Smith, 2019). Later, the military administration was less inclined to use the term "Rohingya," but the people of MFA continued to describe themselves as such. The term "Rohingya" turned out to be an ethnic and political identity (Tonkin, 2017). During the U Nu government, some Rohingya Muslims leaders served as parliament

members (Lee, 2019; Parnini, 2013). One of them, Sultan Mahmud, was the health minister from 1960 to 1962 under the U Nu administration (Leider, 2020).

From 1962 to 2015: Junta Administration – the Rohingyas are shifted from being Citizens to refugees

General Ne Win's coup in 1962 led to increased ethnic discrimination in Myanmar. His military administration banned all political parties, including MFA, except for his own, the Burma Socialist Program Party (BSPP) (Arraiza & Vonk. 2017). During this time, "national race," or taingyintha, became a preeminent political idea in Myanmar. In 1964, the junta government founded the Institute of Development of National Races to advance this idea (Farris, 2017; Kingston & Hanson, 2022). In 1965, the military government scrapped the ethnic Rohingya-language broadcast programs of the Burmese Broadcasting Service (Ullah, 2016). In 1974, the military regime formulated the new Constitution for Myanmar, which recognized 135 races but excluded the Rohingyas (Ullah, 2016). Later that year, the parliament passed the Emergency Immigration Act, requiring all citizens to carry an identity card, called the National Registration Certificate (NRC) (Warzone Initiatives, 2015). However, the Rohingyas were declared ineligible for NRCs; instead, they were offered Foreign Registration Cards (FRCs) (Busyairi & Bui, 2021; HRW, 1996).

This 1974 act was the first official initiative to formally snatch the Rohingyas' citizenship status, making them foreigners in their motherland (Siddiqui, 2005). The Burmese authorities launched Operation "Naga Min" (dragon king) in 1978 to register and verify the status of citizens. This operation expelled more than 250,000 Rohingyas from Myanmar, although

most of them managed to return later (HRW, 2000). The Rohingya repatriation of 1979 was followed by the new Citizenship Law in 1982 that made the Rohingyas legally stateless. This law is the central legal instrument to render Rohingyas' stateless (Chickera, 2021). In 1989, color-coded Citizens Scrutiny Cards (CRCs) were introduced in Myanmar: pink cards for full citizens, blue cards for associate citizens, and green cards for naturalized citizens. The Rohingyas did not receive any cards (Lewa, 2009). In 1995, following UNHCR advocacy, the Myanmar authorities issued the white-colored Temporary Registration Card (TRC) to the Rohingyas. This white card allowed the Rohingyas to cast their votes in the 2010 general elections and 2012 by-elections (Albert & Maizland, 2020). However, these white cards were subsequently revoked in early 2015, barring cardholders from voting or standing for parliament seats in the 2015 elections (Green, Macmanus, & De la Cour Venning, 2015). Thus, the Rohingyas lost their voting rights in 2015, which was the last human right for them in Myanmar.

From 2016 to Today: From Suu Kyi to the present Junta Administration – No change of statelessness

The landslide victory of the National League for Democracy (NLD) in the 2015 elections saw Suu Kyi, the daughter of Myanmar's father of the nation, Aung Sun, become the state counsellor of Myanmar (equivalent to a prime minister). Suu Kyi was the state counsellor and minister of foreign affairs from 2016 to 2021 (Selth, 2021). During this period, the general hope that the miseries of the minority Rohingyas would be alleviated was dashed, and the situation further deteriorated for them (McPherson, 2017). In 2016, during Suu Kyi's regime, the term "Rohingya" was banned from both public and private use (Lloyd, 2016). In 2018, the Myanmar authorities allegedly prohibited Radio Free Asia from using this term (RSF,

2018). Then the worst of all occurred in August 2017, during Aung San Suu Kyi's regime. The military unleashed systematic genocide, including widespread murder, rape, and burning of homes of Rohingyas, forcing more than 700,000 to flee Rakhine (Wright, Hunt, & Berlinger, 2017).

The Myanmar military once again seized power on February 1, 2021, detaining Suu Kyi and other NLD government officials. Since then, nothing positive has happened with regard to the Rohingyas' statelessness status. The remaining 600,000 Rohingyas in Myanmar, including 140,000 confined to camps for internally displaced persons (IDPs), still live without any citizenship rights (HRW, 2023; Root, 2023). The only positive development is that the shadow National Unity Government, formed by the ousted politicians of Myanmar, has declared that it will accept the ethnicity and term "Rohingya" in a future democratic Myanmar (Kamruzzaman, 2021; Rahman, 2022b).

Since Myanmar's independence, the Rohingyas have been issued different types of identity cards. However, after the 1962 military coup, the Rohingya identity cards were either declared invalid or taken away from them. Each replacement card carried fewer rights and more restrictions. Here is a chronology of Rohingya statelessness and the various cards issued to them as a proof of citizenship:

1948 : Full citizenship of Rohingyas with National Registration Certificates (NRCs).

1962 : Since November 5, 1962, no NRCs were issued to Rohingyas.

1974 : Foreign Registration Cards (FRCs) were given designating Rohingyas as non-

nationals under the Emergency Immigration Act.

1978 : Verification of citizenship program expelled more than 250,000 Rohingyas

1982 : Rohingyas became stateless with the enactment of the Citizenship Act. Three categories of citizens – full citizens, associate citizens, and naturalized citizens were introduced, based on 135 recognized races.

1989 : Color-coded Citizenship Scrutiny Cards (CSC) – pink, blue, and green, respectively – were given. Only a few Rohingyas have been issued a CSC.

1995 : Temporary Registration Cards (TRCs), or white cards were given to Rohingyas. White cards did not serve as a proof of citizenship, they only allowed voting rights.

2014 : Rohingyas were excluded from the census count, as the then-Myanmar authorities proposed that they would be counted if they agreed to be labeled "Bengalis."

2015 : Presidential order for the invalidation of white cards.

2016 : Of the 759,672 white cards distributed, 469,183 have been returned and exchanged for new green cards (NVC-National Verification Card).

2017 : Most of the Rohingyas (90%) were expelled from Myanmar; they described NVCs as genocide cards

2017 to today: NVCs are offered to Rohingyas that identify them as non-citizens.

Sources: Own data file compiled from multiple sources: Dulal, 2017; Hein, 2018; Minorities at Risk Project, 2004; MSF, 2022; Ullah, 2019

Data Collection for This Study

The required information for this study was collected from both primary and secondary sources. The study uses both qualitative and quantitative approaches in analyzing the issue. Primary data have been collected through open-ended, in-depth interviews and Focused Group Discussions (FGDs) with Rohingya refugees, utilizing the Culture-Centered Approach (CCA). CCA is a meta theoretical framework that works through dialogue with the research participants so that the local meanings of participants' problems and probable solutions can be articulated and understood. The author conducted 41 in-depth interviews and a number of FGDs of the Rohingyas living in Bangladeshi refugee camps from December 2021 to January 2022. The author also conducted 12 in-depth interviews of the Rohingya refugees during his earlier visit to the camp in February 2020. He first visited the Rohingya refugee camps as a Bangladesh Television (BTV) reporter in July 2018 to cover the news of U.N. Secretary General Antonio Guterres's visit to the Rohingya camps. In addition, the author conducted more than 50 in-depth interviews, joined in a number of FGDs, and recorded participants' observations of the Rohingyas who have been living in New Zealand (resettled through the third-country settlement process of UNHCR). He conducted these interviews in New Zealand between September 2020 and November 2021, while working as a research assistant for the Center for Culture-Centered Approach to Research and Evaluation (CARE) of Massey University. In addition, the author's experiences working as a television journalist and covering the Rohingya crisis from 2017 to 2020 and his current involvement as a Rohingya researcher have been utilized in this article.

This article refers to only a small number of individual stories. However, the semi structured, in-depth interviews and observations carried out over a six-year period outlined the lived experiences of all the Rohingya refugees. As mentioned above, more than 100 in-depth interviews were conducted during two extensive field visits to Cox's Bazar camps and the author's more than three years of work with the Rohingya refugees living in the city of Palmerston North in New Zealand. In addition, oral histories of the Rohingyas were collected, and participant observations were recorded at different family gatherings, community events, and everyday activities as the author and the Rohingya refugee families interacted with each other in Palmerston North. Also, the author's work with the New Zealand Red Cross as a settlement cross-cultural worker helped him gain insights into the lived experiences of Rohingya families and their cultural and historical backgrounds.

The Culture-Centered Approach to Refugee Studies

The culture-centered approach is an analytical framework that foregrounds the intersection of culture, structure, and agency (Dutta, 2008). In CCA, cultural contexts are the entry points for theoretical insights to describe any community-led solutions experienced by a marginalized community like the Rohingya refugee community (Kumar, 2020). CCA unlocks the definition, meaning, and design of participation to community voices (Rohingya refugees), with the goal of building theories from below (Dutta, 2007). Those who practice CCA believe that the community is the best place to solve any problem experienced by the cultural members of a subaltern community (Dutta, Moana-Johnson, & Elers, 2020). Dialogue between researchers and participants appears as a tool in CCA, where the lived experiences of the participants are used to find out community-driven solutions (Dutta, Zhuo, & Pal,

2012). CCA argues for the central role of community participation through dialogue to define any problem faced by the community — for example, the members of the Rohingya refugee community, who are "systematically erased from dominant discursive spaces of knowledge production" (Dutta, 2011, p. 3).

Statelessness: The Root Cause of the Rohingya Crisis

The Rohingya crisis is a multi-dimensional, long-standing quandary that has remained unresolved for more than 75 years, since Myanmar achieved its independence. With the denial of citizenship under the 1982 Citizenship Act, the Rohingyas were rendered stateless in their country, and they lost basic human rights, such as the right to protection. The state-sponsored discrimination and atrocities against the stateless Rohingyas have resulted in a massive wave of forced migrations to neighboring countries.

A Rohingya man (age 65) living in New Zealand, who came to this country from Malaysia under the UNHCR's third-country resettlement process, observed that statelessness was the main cause of their persecutions in Myanmar. It is worth mentioning here that, during our interview, the man continued to use the name "Burma" instead of Myanmar. When this author drew his attention to this, he responded, "My country is Burma, not Myanmar." He said the Burmese government intentionally changed Arakan's name to the state of "Rakhine." He emphatically declared that,

> we are Arakanese. We do not know Rakhine or Myanmar. We are Arakanese or Burmese and, of course, Rohingya.

He continued:

> We the Rohingyas are not terrorists. But the Burmese military government tried to label us as terrorists. From 1962, we are oppressed and persecuted. Even we could not go to another village without permission. And, from 1982, we are totally stateless and lost all our rights. I think before the independence of Burma in 1948 and some years after the independence, Rohingyas were in good condition. Then in 1962 when the Army took the power, Rohingyas lost everything.

The Rohingya refugees are also known as "boat people" in the outside world, as they risked their lives to reach a developed country, voyaging in wooden boats (McKirdy & Mohsin, 2015). Rohingyas used to undertake boats journeys from Myanmar to flee genocide and persecution, but now they undertake it to escape cramped and overcrowded camps in Bangladesh in search of a better life (Khin, 2023). This author spoke with some of these Rohingya "boat people" who came to New Zealand from Malaysia under the third-country resettlement program. They said that they had been forced to leave Myanmar as the authorities denied them citizenship. One Rohingya man (age 33) who fled Myanmar through boat mentioned:

> I left my country, Burma (Myanmar) in 2008 without any identity document via a boat. After 18 to 20 days of boat journey, I reached Thailand from Burma. Even some days (during the journey), we had only salty sea water to drink as there was shortage of food in the boat. After some days in Thailand, I managed to enter Malaysia. The whole boat journey was carried out with the help of a "Dalal" (broker). I had to pay him a lot of money.

This man explained his decision to leave the country in the following way:

> I had taken the decision to leave my country as I was unable to study or find a job. My siblings are younger than me, but I could not help them. Sometimes even we could not manage our foods. In 2008, I was 20 years old. At that time, there was no opportunity in my country to educate ourselves, no opportunity to work. As stateless Muslims, we could not even move freely. The "Maugh" people [Rakhine Buddhists], who lived in my village as neighbors, always insulted us, disturbed us, and even persecuted us. Seeing all these, I had decided to leave my motherland.

A Rohingya female interviewee (age 58) at a refugee camp in Cox's Bazar, Bangladesh who fled in August 2017, insisted that they were Rohingyas and loved to be identified as Rohingyas. During the interview, she asked this author to call her a Rohingya as it was her ethnicity and identity. When the elderly lady mentioned the loss of lives of many Rohingyas and their properties, she could not hold back her tears. The interviewee observed:

> We are Rohingyas. You should also call us Rohingya. We want to live as Rohingya, we want to go back to our country [Myanmar]. We want to move and walk freely in our country. We have the same rights as the Maugh people [Rakhine Buddhists] are currently enjoying; we want back those rights in Myanmar. We lost everything as we are stateless. In 2017, my sister's daughter and her husband were killed by the Burmese military. We want back our citizenship rights and live in our ancestor's land peacefully.

Rohingya Statelessness Needs to be Addressed

This study argues that although there are many causal factors pertinent to the Rohingya crisis — such as Islamophobia, racism, economic interests, and power dynamics — statelessness is the root cause of all the problems. Resolving the statelessness or Rohingya nationality issue can fix most of other issues. The "stateless" Rohingyas cannot protest misdeeds perpetuated against them or seek redress in the justice system. This author's experience of working on the Rohingya issue for more than six years has made him aware that the legal recognition of Rohingyas as Myanmar citizens would resolve the crisis once and for all. This recognition will enable them to enjoy all the social, political, and civil rights of other citizens. Interviewees for this study also categorically mentioned that the statelessness crisis should be resolved first.

When Rohingyas fled persecution in 1978 and 1991, the UNHCR facilitated their repatriation to Myanmar without addressing the root cause of their forced migration, which was their identity of statelessness. Consequently, persecutions against the Rohingyas have been continuing unabated until today. During the interviews at one of the Cox's Bazar refugee camps, the author encountered a Rohingya man (age 62) who had fled Myanmar three times. The Rohingya man mentioned that in 1978, when the Myanmar military started to scrutinize their citizenship identity, he first came to Bangladesh. Then, in 1991, he came again. Finally, in August 2017, this man fled Myanmar to avoid the atrocities perpetuated by the local authorities. From 1978 to 2017, for 39 years of his life, he could not find a secured place in Myanmar due to his stateless status. He described his toing and froing in the following way:

> In 1978, I fled to Bangladesh for the first time when the Burmese authorities scrutinized our identity document (citizenship). Then I went back to Burma after 2 to 3 years. Again, in 1991, I was tortured by the Burmese government people and forced to come to Bangladesh. I stayed two years here in Bangladesh. Again, I went back to Burma and tried to stay there. At that time, just after 10 days of our arrival in Burma, torture and persecutions started against us. Then, they had taken our houses, lands, property, and placed us in a camp [i.e., IDP camps]. After living 20 years in IDP camp, I managed to flee and came to Bangladesh in August 2017.

Currently, the highest number of Rohingyas, more than 1.6 million, live in Bangladesh. The Bangladeshi government considers repatriation as the only viable solution to the Rohingya crisis. However, the Rohingyas living in various camps demanded that their citizenship issue should be resolved first. A Rohingya youth (age 29) interviewed by the author at a Cox's Bazar refugee camp, who also fled from Myanmar in 2017, observed that they were interested in going back to Myanmar if citizenship rights had been ensured. He talked about five demands to be fulfilled before their repatriation from Bangladesh to Myanmar:

> Our demands are—at first, we want security; then our citizenship right, our freedom of movement, free and fair marriage rights, our religious right of practicing Islamic rituals, and lastly, our right to get government jobs. If these five demands are fulfilled, we will definitely go to our country, Myanmar. Returning of our citizenship right is the main demand. And our lands and other properties taken away by the Burmese government should be returned to us.

There is a saying in the Rohingya language: “Duniyaye Burmarttun waro Roaingare beshi sine,” meaning “Rohingyas are better known around the world than Myanmar itself” (Johar, 2021). This saying also means that the term “‘Rohingya’” is now well accepted all over the world, although the crisis has yet to be resolved (Rahman, 2022a). The policy literature produced by various international aid agencies, humanitarian organizations, and think tanks, — such as Amnesty International, Human Rights Watch (HRW), and Fortify Rights, — argues for amending the 1982 Citizenship Act to enable the Rohingyas to get back their citizenship rights. For example, a Euro Burma Office briefing paper claims that “until the 1982 Citizenship Law is changed, the status of Arakan Muslims (Rohingyas) will remain in limbo” (EBO, 2009, p. 3).

Discussion

Citizenship, or nationality, is a fundamental human right that facilitates other rights. According to Article 15 of the Universal Declaration of Human Rights (1948), “everyone has the right to a nationality,” and “no one shall be arbitrarily deprived of his nationality” (U.N. Booklet, 2015). However, despite Rohingyas’ substantial historical presence in Myanmar, Myanmar does not recognize the Rohingyas’ identity. Rather, the state of Myanmar has converted the Rohingyas to be stateless (Pugh, 2013). According to Linda Bosniak, a reputed scholar, citizenship is composed of four components: legal status, rights, political activity, and identity (Bosniak, 2000). The Rohingyas are unable to demand any rights in Myanmar due to the stripping of their legal status. Instead, they have been fleeing state-sponsored persecutions in Myanmar since 1962. Their statelessness has been the key element in their decades-long persecutions in Myanmar. This factor is also a key reason for their lack of protection as refugees outside Myanmar (Kader & Choudhury, 2019).

In today's world, a citizenship document is the gateway to all rights for a migrant, asylum seeker, or refugee. Conferring citizenship on the Rohingyas, the largest stateless community living in Myanmar and elsewhere, is the best way to begin resolving the crisis. The Kofi Annan Advisory Commission had urged Myanmar to review the Citizenship Law of 1982 to bring peace to Rakhine state (Khaine & Htway, 2017). While the National Unity Government enjoys popular support in Myanmar, it does not have the power to address the problem of the Rohingyas' citizenship documentation. The present military government of Myanmar lacks popular support in the country, but it governs the country. The international community, if sincere about resolving the crisis, should put further pressure on the present Myanmar military government to address the Rohingyas' legal citizenship issue. This author's long experience conversing with the Rohingya crisis indicates that a permanent solution to the crisis lies in the Myanmar government's intention to recognize the Rohingyas and grant them citizenship.

Recommendations

- Full legal recognition of the right to citizenship and issuance to them of appropriate civil documentation to all Rohingya people, irrespective of their residing countries should be ensured first.
- For ensuring citizenship of Rohingyas, the 1982 Citizenship Act of Myanmar should be amended in line with international standards.
- The "Rohingya" ethnic status needs to be ensured.
- Since the military coup of February 2021, Myanmar has been governing by the military, so dialogue between the military and Rohingya is important. Again, as

Rakhine state is governed by the Arakan Army, a tripartite dialogue between the militia, the Arakan Army, and the Rohingya should be organised.

- Any repatriation of Rohingyas from any country should be safe, voluntary, and sustainable. The repatriation effort should be supervised by the U.N. bodies.
- Without resolving the root cause of the Rohingya crisis, — that is, without ensuring citizenship rights for the Rohingyas, — no repatriation should be undertaken.
- Community rehabilitation and integration of Rohingyas should be prioritized in Myanmar, including through identifying and combating hate speech.
- Bangladesh government should work with the UNHCR to resume the third-country resettlement process for the Rohingyas living in the country.

Conclusion

The current Rohingya crisis is complex. A durable resolution to the problem is difficult. Since the latest Myanmar military coup in February 2021, the crisis has become even more complex. Safe, voluntary, and sustainable Rohingya repatriation from various countries to Myanmar will be the best fix for this crisis. However, unless the Rohingya statelessness issue can be resolved, the repatriation may be futile. This futility was evident in the cases of repatriation after the 1978 and 1991-92 exoduses. A long-term, permanent solution is required that will help the Rohingyas repatriate from Bangladesh and other countries to Myanmar peacefully and stay there safely.

Providing humanitarian aid to the Rohingyas is not the real solution to the crisis. Rather, measures for effective repatriation are required, with the help of regional and international bodies, so that the Rohingya crisis can be permanently ended. International organizations, —

such as the United Nations, Organization of Islamic Cooperation, European Union, and ASEAN, — should come forward wholeheartedly to settle the crisis. Especially, genuine interest from Myanmar's two giant neighbors — China and India — is crucial. Myanmar regularly enjoys pivotal support from China. Consequently, critics sometimes describe Myanmar as a "de facto Chinese client state" (Zhao, 2008). Myanmar is also the gateway for India's "Act East" policy, and thus is receiving heavy economic attention (Atmakuri & Izzuddin, 2020). These factors point the genuine interest of these two neighbors, which is crucial for resolving the Rohingya crisis. However, as stated above, the root cause of the crisis — the Rohingyas' stateless identity — needs to be fixed first; unless this issue is resolved, the Rohingya crisis cannot be settled.

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Chapter 8: Conclusion, Limitations and Future research

8.1 Introduction

With limited health and hygiene facilities, the entire refugee camp area of Cox's Bazar still possesses the "characteristics of a likely epicentre of disease transmission" (Jubayer et al., 2023, p. 2). Despite some infrastructural developments, such as roads, health facilities, water supply and improved cooking services (i.e., LPG use), the overall situation in the Rohingya refugee camps in Bangladesh remains dire. Six years have elapsed since the mass exodus of Rohingyas from Myanmar to Bangladesh. Still, around one million Rohingyas are confined to the congested camps of Bangladesh. In 2017, the U.N. High Commissioner for Refugees declared that the Rohingya refugee crisis was "the most urgent refugee emergency in the world." However, after six years, the scenario remains the same or worse (Reid, 2023). For example, the WFP's $12 food aid per person per month for the last five years was reduced to $8 in 2023. The $8 per person per month means 27 cent per day or 9 cent per meal. With no opportunity of paid work, the Rohingyas must sustain themselves with the extremely limited food intake afforded to them for nine cents a meal in the current post-pandemic scenario of economic hardship. In these circumstances, the poor overall health of the Rohingyas can easily be understood.

WFP food assistance, which is seriously threatened by the food aid cuts, is the only lifeline for the Rohingya refugees. Before the recent cuts, each Rohingya individual received a minimum standard of approximately 2,100 kilocalories (Kcal) per day. The new food ration provides them with less than 1,700 Kcal per day (Tafhim, 2023). About 45% of the

Rohingyas refugees had not received sufficient food intake even before the aid cuts. The newly reduced food ration is exacerbating malnutrition and hunger among the Rohingyas. During my fieldwork, I observed that health means "just to live" for the Rohingyas. The recent reduction in food aid means more hunger among the Rohingya refugees of Bangladesh. Dutta (2012) articulated a grim reality of "hunger as health" for some, which has become an unfortunate reality for the Rohingyas in Bangladesh.

The overall health of the Rohingya refugees, living in makeshift camps for years on end, is deteriorating every day. To ensure the health of this vulnerable group, the decades long Rohingya crisis needs to be resolved. However, the all-important question is how this will be done. What strategies can be adopted to resolve the crisis and who will take the initiative? Many analysts believe that the ultimate solution of the Rohingya crisis depends on their safe, voluntary, dignified, and sustainable return from the host countries. The question is how the Rohingyas will be repatriated to their homeland as Myanmar is not yet ready to receive them. As the Myanmar authorities have created the Rohingya problem, they must come forward with the solution. However, nothing has been achieved so far in this regard. The root cause of the Rohingya crisis, their statelessness, should be resolved first. Otherwise, any repatriation effort will be futile.

The role of the international community is very important in making Myanmar agreeable to resolving the Rohingya crisis. I have discussed the role of international community including that of the powerful neighbours China and India in my policy article titled "Statelessness – the Root Cause of the Rohingya Crisis – Needs to Be Addressed." This article has been included in Recommendations and Praxis chapter [7.5 (a)]. As everyone believes that the sustainable solution to the Rohingya crisis is their repatriation to the homeland, necessary

steps need to be taken to ensure repatriation in a dignified manner. Bangladesh has been keen to start the repatriation process through bilateral and multilateral talks, but to no avail. The involvement of the United Nations, and the international community, especially China and India, as well as inclusion of the Rohingya voice in the repatriation discussions and ensuring their citizenship rights in Myanmar, may lead to a practical and sustainable solution to the Rohingya crisis.

8.2 Limitations of this study

Initially, selecting an appropriate sampling approach was challenging as I was not hugely familiar with the Ukhiya camp setting. It was mentioned in the RRRC permission letter that I should contact the CICs (Camp-In-Charge) first to enter any camp. So, in the early days of my field work, I tried to follow the procedure. With support from the CIC, I could easily find respondents as the CIC provided a Rohingya volunteer as his representative who recruited participants for me. However, it created a challenge to figure out the real scenario of the camps or the living status of Rohingyas as the respondents did not feel free enough to open up and describe their lived experiences in front of the CIC representative. So, after the initial two days of my fieldwork, I did not take any help from the CIC. Rather, my Rohingya interpreter (i.e., community researcher) and I selected the participants utilising applied referral methods.

The RRRC permission letter noted that I could enter the Rohingya camps only on the weekdays. This condition imposed a limitation on my entry into the camps. As a result, although I stayed 19 days in Ukhiya upazila, I could enter the Rohingya camps on only 12 days. Another condition in the letter was that I had to leave the camps before 3:30 pm each

day, which also created obstacles in the number of interviews I could conduct in a day. I managed to record 41 in-depth interviews during my entire stay in Ukhiya. I was compelled to conduct the highest number of 13 interviews at Camp 7 as I stayed very close to that camp. I took a special initiative to visit the Hindu Rohingya para as the spot was 30-40 minutes' drive from where I stayed. During the Hindu para visit, my community researcher was unable to accompany me. So, I sought help from my BTV colleague from Ukhiya and visited the spot.

As a male researcher, I faced a challenge in conducting interviews with the female Rohingyas'. Initially, I planned to recruit a female Rohingya interpreter for this purpose. However, I could not find any suitable female Rohingya who knew Bengali and who would be interested in working as an interpreter. As a result, I suspect I did not get a proper picture of the Rohingya women's health issues including their sexual and reproductive health (SRH) matters. In the Rohingya culture, SRH issues are considered as taboo, shameful, and unacceptable to be discussed openly, especially with a male stranger (Ahmed et al., 2020). Though menstrual health, family planning, sexually transmitted infections (STIs) and abortion are a big challenge in the Rohingya camps, as a male researcher, I could not obtain any clear idea regarding these issues. The challenges I faced during my fieldwork and the required improvisations and strategies adopted have been discussed in my article titled "Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh." This article is included in chapter four (4.3.3 section) of this thesis.

8.3 Personal journey and research reflection

I started to work with the Rohingya refugee crisis in August 2017, when the largest exodus of Rohingyas started to flow towards Bangladesh. At that time, I was working as a news producer of the Bangladesh Television, a state-owned TV channel of the country. I could recall that at the initial stage, we did not even understand from an editorial standpoint of a public service TV, how to treat this news of the persecuted people who had been trying to enter Bangladesh. When the Rohingyas tried to cross the border, the Bangladeshi authorities were also in uncertain territory as to whether they should open the border for them (Alam, 2018). Then, with a quick decision from the Prime Minister Sheikh Hasina, they opened Bangladesh's border to the persecuted Rohingyas. As a quick note, I must say that in the early days of the August 2017 exodus, we at the BTV newsroom were not even certain whether the state-owned TV channel should call the people "Rohingyas." The term was, and still is, banned in official Myanmar communication. We were concerned about the implications of using this term for Bangladesh's diplomatic relations with Myanmar and other stakeholders pertinent to this issue. However, following the government decision to open the border, we started to call them "Rohingyas." I was assigned the responsibility of preparing all BTV news stories (i.e., news bulletin stories, current affairs program stories, documentary scripts, etc.) relating to the "Rohingya crisis."

In July 2018, the UN Secretary General Antonio Guterres came to Bangladesh to visit the Rohingya refugee camps at Cox's Bazar. As I was responsible for producing the Rohingya crisis-related news stories at BTV, I was also assigned to cover the Secretary General's visit. In this connection, I visited the Rohingya refugee camps in July 2018 for the first time, along with the entourage of the UN Secretary General. While working with the Rohingya refugee crisis in Bangladesh Television, I got the opportunity to start my PhD research on Rohingya

health at Massey University in New Zealand. Before coming to New Zealand for my study, I visited the Rohingya camps again in February 2020 for a pilot study of my PhD research. I conducted 12 in-depth interviews of the Rohingyas at that time. In March 2020, I came to New Zealand and started to deal with the Rohingya refugees resettled in this country while working as a Research Assistant at the Centre for Culture-Centred Approach to Research and Evaluation (CARE), Massey University.

I am lucky that my PhD research and work as a Research Assistant at CARE are related to each other, as in both cases the participants are the Rohingyas. My PhD research is on 'Rohingya health' of the refugees living in the Bangladeshi refugee camps. At CARE, I have been dealing with the 'Rohingya health' of the former refugees[21] (Rohingyas) resettled in Aotearoa New Zealand. While working at CARE, I have conducted more than 60 in-depth interviews of the former refugees (Rohingyas) living in Palmerston North. For my PhD research fieldwork, I visited the Rohingya camps in Bangladesh for the third time in December 2021- January 2022 and took 41 in-depth interviews of the Rohingyas living in the Cox's Bazar camps. In total, I have conducted more than 100 in-depth interviews of the Rohingyas living in Bangladeshi Rohingya camps and New Zealand. My work as a news producer at BTV and as a research assistant at CARE helped me to become a Rohingya researcher. The entire body of my work related to the Rohingya crisis, including the production of news reports, participating in panel discussions, presenting paper at conferences, has been described in Table 3: Rohingya participant observation timeline in Chapter 4 (4.1.3 section). From August 2017 until today, I have been working with the Rohingya refugee crisis and showing my solidarity with their decades-long struggle.

[21] When a refugee is accepted by New Zealand under third country resettlement process, the refugee has been given permanent residence (PR) of this country. So, after arrival of this country the refugees are termed as 'former refugees.' (Reeve, 2020)

8.4 Future research

The issues pertaining to the meanings of health among the Rohingya refugees in Bangladesh have not been studied before. This is also the first study among refugees living in a camp setting that utilised the Culture-Centred Approach. This approach should be further explored in future research endeavours as this theory engages communities in marginalised settings. I would like to see further research on the top-down power structures that erase the Rohingyas' voice and how their absent voice can be incorporated at the discussion level. As the Rohingyas' voice has been totally absent from any discussions since their first arrival in Bangladesh in mid-1970s, more research on the voice of the Rohingyas' is much needed. With no place to call their home, and with no livelihood opportunities, the voice of these stateless people should be heard to find any solution for the Rohingyas. The Rohingyas currently live on only 27 cents per day or nine cent per meal. There is a need to further explore the impact of this extremely limited food intake on their health.

Reflecting on the 'margins of the margins' concept this study demonstrates the complexity of marginalisation and power inequalities endured by Rohingya refugees living in a third world country, Bangladesh. This study contributes to culture-centred scholarship that has shown how structures limit health choices of Rohingyas by the patterns of unequal access to resources. Though the Rohingya refugees in Bangladesh epitomise the 'margins of the margins,' community yet they are absent from communication scholarship. While Rohingya refugees have been largely overlooked in communication research, this study highlights the need to explore and amplify Rohingya voices. Further research is very crucial to centre structural inequities in inclusion by actively working with Rohingya refugee communities situated in the 'margins of the margins' context.

I would like to end this thesis with some of the Rohingya voices or apt snippets I collected in this study that sharply capture the essence of the meaning of health, challenges, and solutions. The voices are shared in solidarity with the reclamation of constructing health and wellbeing of the Rohingyas:

> In this camp the meaning of health means how we can live with proper security. Health means in my daily life, I should be happy 24/7. But in refugee life health is also a refugee.

> The Myanmar authorities' intention is that they want to keep us (Rohingyas) illiterate so that we cannot move forward, we cannot demand anything.

> The primary (root) cause of becoming a refugee is the deprivation of education. We did not get education in Myanmar and now our kids also do not get education in Bangladesh.

> In Bangladesh, we are registered as FDMN (Forcibly Displaced Myanmar Nationals). If we were registered as refugees, then I think that would be better for us.

> The Myanmar authorities called us Bengali, but we are not Bengali, we are Rohingya. As we are Rohingyas we want the solution that Myanmar government should recognise us as Rohingyas. If they give us our citizenship rights, and other rights then we will go to my country. Only we have the hope that one day we will go. Until then, we only wait and wait.

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Appendices

Appendix A: Sample questions of the interview

It is a sample of some potential questions used in the interview. The in-depth interview has been taken by open-ended questions.

আসালামুআলাইকুম (Assalamualaikum)

আমার নাম মু: মাহবুবুর রহমান (My name is Md Mahbubur Rahman)

আমি নিউজিল্যান্ডের মেসি ইউনিভার্সিটিতে পি এইচ ডি করছি (I have been doing my PhD at Massey University, New Zealand)

আমার পি এইচ ডি'র বিষয় আপনারা অর্থাৎ রোহিঙ্গারা (My PhD topic is Rohingya related)

আমি নিউজিল্যান্ড থেকে এখানে এসেছি আপনাদের সম্পর্কে জানতে (I come here from New Zealand to know more about you)

আপনি আমার এ গবেষণা কাজে সহযোগিতা করতে রাজি আছেন তো? (Do you agree to take part in my research)

আমার এবং আপনার কথোপকথন রেকর্ড করা হবে, শুধুমাত্র আপনার কথা রেকর্ড হবে, কোনো ভিডিও করা হবে না (Our conversation will be recorded, only audio-recording no video)

আপনি রাজি আছেন তো ? (Do you agree?)

আপনি এখন কেমন আছেন? (How are you, now?)

আপনি কবে প্রথম বাংলাদেশে এসেছেন? (When did you first come to Bangladesh?)

এটা কি আপনার বাংলাদেশে প্রথম আসা? (Is that your first-time entry into Bangladesh?)

বাংলাদেশে আসার পর সর্ব প্রথমে আপনি কোথায় ছিলেন? এবং কতদিন ছিলেন? (Where did you take shelter after coming to Bangladesh and how long you stayed there?)

এই ক্যাম্পে কবে এসেছেন? (When did you come to this camp?)

আপনি যেখানে বাস করছেন এটা কি আপনি নিজে বানিয়েছেন নাকি সরকার তৈরি করে দিয়েছে? (The shelter where you are now living, is that made by you or supplied by Bangladesh Govt?)

বাসস্থানের এই জমি কি কিনতে হয়েছে নাকি সরকার দিয়েছে? (Did you need to purchase the land for your shelter?)

নিজেকে জমি কিনতে কত টাকা দিতে হয়েছে? (How much money did you to give landlord to buy this land?)

এই বাসস্থানে আপনারা কতজন বসবাস করেন? (How many people live in your shelter?)

এখানে বাস করতে কী কী কষ্ট হয়? (What difficulties do you face to live in your shelter?)

বৃষ্টি হলে কি চাল দিয়ে পানি মেঝেতে পরে? (When it rains, does the water fall on the floor?)

এখানে বসবাসের শুরুর পর থেকে কি এই বাসস্থানের কোনো মেরামত করতে হয়েছে? (Has there been any repairs to this shelter since the start of your living?)

মেরামতের টাকা কি সরকার দেয়? নাকি সরকার মেরামতের সামগ্রী দেয়? (Does the government pay for repairs? Or the government provides repair materials?)

এই চার বছর পর ক্যাম্পে আপনি কেমন আছেন? (How are you doing in the camp after the four years of 2017?)

এই চার বছরে কি কোন কাজ করার সুযোগ পেয়েছেন? (Have you had the opportunity to do any work in these four years?)

(জবাব হ্যাঁ হলে) কি ধরণের কাজ ছিল? (If yes, What type of work was there?)

সেই কাজের টাকা দিয়ে কী করেছেন? (What did you do with the money for that job?)

যে কাজ করেছেন তা কী এই ক্যাম্পের ভিতরে ছিল নাকি অন্য ক্যাম্পে নাকি ক্যাম্পের বাইরে? (Was the work done inside this camp or in another camp or outside of the camp?)

আপনি কী চাইলেই ক্যাম্প থেকে বের হতে পারেন? (Can you leave the camp whenever you want?)

আগে কি বের হতে পারতেন? (Could you have come out from the camps earlier?

ক্যাম্পে কিভাবে বেঁচে আছেন? (How are you living in the camp?)

আপনার মতে কোনো কাজ করার সুযোগ নেই, রেশন কত পান মাসে? (In your opinion, there is no opportunity to work, how much food rations do you get in a month?)

যে রেশন পান তা দিয়ে কি সংসার চলে? (Does the family survive on the food ration they get?)

রেশনে কি কি পান? (What items do you get in the food ration?)

প্রতিমাসে কি একই খাবার আইটেম পান, নাকি ভিন্ন? (Do you get the same food item each month, or different ones?)

আপনি কি চাইলে কোনো কিছু বাজার থেকে কিনতে পারেন? (You can buy anything from the market as per your wish?)

ক্যাম্পে খাবার কিভাবে রান্না করেন? (How do you cook food in the camp?)

যে এল পি জি গ্যাস সিলিন্ডার পান, তা দিয়ে কি মাস চলে? (Does your LPG cylinder enough for your family cooking for a month?)

আপনাদের প্রধান খাবার কি? মিয়ানমার এবং এই ক্যাম্পে খাবারের মধ্যে কী পার্থক্য আছে? (What is your staple food? What is the difference between the food in Myanmar and this camp?)

এই ক্যাম্পে কতজনের জন্য একটি ল্যাট্রিন? (A single latrine is for how many people in this camp?)

কতজনের জন্য একটি গোসলখানা? (How many people use a single bathroom in this camp?)

খাবার পানি কোথা থেকে পান? (From where you get the drinking water?)

এ জীবনে পড়াশোনার সুযোগ পেয়েছেন? (Do you get any opportunity of education in your life?)

বাচ্চারা কি পড়াশোনা করে? পড়লে কি পড়ে? (Do your kids study? If yes, where do they study)

আপনার পরিবারের সদস্য সংখ্যা কত? (What is the total member of your family)

আপনার ক্যাম্পে কী কোনো বিদ্যুৎ সরবরাহ আছে? (Does your camp have any electricity facility?

আপনার কি মোবাইল ফোন আছে? (Do you have mobile phone?)

মোবাইল কিভাবে রিচার্জ করেন? (How do your charge your mobile?

ক্যাম্পে মোবাইলের নেটওয়ার্ক কেমন? (How is the mobile network in the camp?)

এই ক্যাম্পে কিংবা বাংলাদেশে আসার পর কি কোনো সন্তানের জন্ম হয়েছে? (Has any child been born in this camp or after coming to Bangladesh?

বাচ্চার জন্ম কোথায় জন্ম হয়েছে? আপনার ঘরে নাকি হাসপাতালে? (Where was the baby born? In your home or in the hospital?)

আপনি স্বাস্থ্য বলতে কি বোঝেন? (What do you mean by health?

আপনার স্বাস্থ্যগত সমস্যা আপনি কিভাবে মোকামেলা করেন? How do you deal with your health problems?

পরিবারের কেউ অসুস্থ হলে কোথায় যান? (Where do you go if someone in the family becomes sick?

আপনার ক্যাম্পে কি কোনো স্বাস্থ্য কেন্দ্র আছে? থাকলে কয়টি আছে? (Is there a health centre in your camp? If so, how many are there?

আপনার ক্যাম্প থেকে ফিল্ড হাসপাতালের দূরত্ব কত? (How far is the field hospital from your camp?)

অসুস্থ হলে কোথায় যান, স্বাস্থ্য কেন্দ্র নাকি ফিল্ড হাসপাতাল? (If sick, where do you go, health center or field hospital?

হাসপাতাল কিংবা স্বাস্থ্য কেন্দ্রে ডাক্তার কি সব সময় থাকে? Is there always a doctor in the hospital or health center?

ডাক্তারদের ব্যবহার কেমন? (How is the attitude/behaviour of the doctors?)

হাসপাতাল কিংবা স্বাস্থ্য কেন্দ্রে কতক্ষন অপেক্ষা করতে হয়? (How long to wait at the hospital or health center?)

ঔষধ কি বিনা পয়সায় পান নাকি টাকা দিতে হয়? (Do you get medicine for free or do you have to pay?)

হাসপাতাল কিংবা স্বাস্থ্য কেন্দ্রে কি কি ঔষধ পান? (What medicines do you get at the hospital or health center?)

নিজের টাকায় কি কখনো ঔষধ কিনে খেয়েছেন? কি কারণে কিনেছেন? (Have you ever bought medicine with your own money? Why did you buy it?)

করোনার সময় কেমন ছিলেন? (How were you during Corona or COVID-19 period?)

করোনা ভ্যাকসিন কি পেয়েছেন? (Did you get the corona vaccine?)

মিয়ানমারে কিংবা বিদেশে কি কোন আত্মীয় স্বজন আছে? (Do you have any relatives in Myanmar or abroad?)

তাদের সঙ্গে কিভাবে যোগাযোগ করেন? (How do you communicate with them?)

মিয়ানমার থেকে কেউ কি বাংলাদেশে আসতে চায়? (Does anyone from Myanmar want to come to Bangladesh?)

আপনি কি মিয়ানমারে ফেরত যাবেন? (Will you go back to Myanmar?)

অনেক দিন যাবৎ তো এই ক্যাম্পে আছেন। কি করলে আপনাদের এখানে থাকা আরো ভালো হতে পারে? (You have been in this camp for a long time. What are your suggestions to make your stay here better?)

আপনাকে ধন্যবাদ। (Thank you)

Appendix B: Participant Consent Form

Construction of health among the Rohingya refugees in Bangladesh: A Culture-Centred Approach

PARTICIPANT CONSENT FORM

I have read, or have had read to me in my first language, and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study. I understand participation is voluntary and that I may withdraw from the study at any time. No identifiers will be used in the interview to protect my identity and only the research team will have access to the transcribed interview.

I understand that my response will be pooled and not be connected to my individual interview.

1. I agree/do not agree to the interview being sound recorded.
2. I wish/do not wish to have my transcripts returned to me.
3. I agree to participate in this study under the conditions set out in the Information Sheet.
4. I agree/do not agree to be contacted with information should there be another stage of the research project that I can be involved in.

Declaration by Participant:

I __ _____ hereby consent to take part in this study.

Signature: _____

Date: _____

Appendix C: Demographic sheet

Construction of health among the Rohingya refugees in Bangladesh: A Culture-Centred Approach

1

DEMOGRAPHIC INFORMATION SHEET

A1 What is your gender? (Tick only **ONE**)

1 ☐ Male		3 ☐	Other (Please state):
2 ☐ Female			

A2 What is your age? (Tick only **ONE**)

1 ☐ 18-25		6 ☐	46-55
2 ☐ 26-35		7 ☐	56-64
3 ☐ 36-45		8 ☐	65 and above

A3 What is your current occupational status (Tick only **ONE**)

1 ☐ Employed		6 ☐	Retired
2 ☐ Employed Part-Time		7 ☐	Unable to work due to disability of long-term illness
3 ☐ Unemployed		8 ☐	Casual / freelance work
4 ☐ Homemaker		9 ☐	Other (Please state):
5 ☐ Student			

A4 What is your occupation? (Please state)

A5 Marital status (Tick only **ONE**)

1 ☐ Married		4 ☐	Widowed
2 ☐ Living as married / de facto		5 ☐	Separated
3 ☐ Divorced		6 ☐	Single, never been married

A6 What is your spouse's occupation? (If applicable, please state)

A7 Total family member

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A8 Highest education level attained (Tick only **ONE**)

1 ☐	No education/school	6 ☐	Polytechnic
2 ☐	Pre-primary	7 ☐	Professional Qualification and other diploma
3 ☐	Primary	8 ☐	Bachelor's degree
4 ☐	Secondary	9 ☐	Master's degree
5 ☐	Post-secondary (non-tertiary)	10 ☐	Other

A9 Thinking about members of your family living in your household, what is your combined monthly income? (Tick only **ONE**)

1 ☐	Below Tk.1,000	5 ☐	BDT 4,000-4,999	9 ☐	BDT 8,000-8,999
2 ☐	BDT 1,001- 1,999	6 ☐	BDT 5,000-5,999	10 ☐	BDT 9,000-9,999
3 ☐	BDT 2,000-2,999	7 ☐	BDT 6,000-6,999	11 ☐	above BDT 10,000
4 ☐	BDT 3,000-3,999	8 ☐	BDT 7,000-7,999		

A10 Which ethnic group do you belong to? (Tick **the box or boxes** that apply to you)

1 ☐	Rohingya		
2 ☐	Burmese		
3 ☐	Other (Please state):		

A11 Where do you born in (Country and District Name):

A12 When did you come to Bangladesh (Year)?

A13 Religious Affiliation (Tick **the box or boxes** that apply to you)

1 ☐	Muslim		
2 ☐	Hindu		
3 ☐	Christian		
4 ☐	Other		

Reimbursement for participating in the interview

Voucher Amount	Date	Participant's Name	Participant's Signature
BDT 100/-			

Appendix D: Information sheet

Construction of health among the Rohingya refugees in Bangladesh: A Culture-Centred Approach

INFORMATION SHEET

You are invited to participate in a research project that aims to find out the meanings of health among the Rohingya refugees living in the camps of Bangladesh.

This information sheet provides you with information about the research. The Principal Investigator Md Mahbubur Rahman under the supervision of Professor Mohan Dutta, of Massey University, New Zealand will also describe this research to you and answer all of your questions. Please read the information below and ask questions about anything you don't understand before deciding whether or not to take part.

What is the expected duration of my participation?

You will be asked to recount your personal experiences of health in the refugee camps of Bangladesh and to discuss solutions to health interventions as you see them. The interviewer will ask you to share your perspectives through broad open-ended questions about challenges and solution strategies in your community regarding health issues. The interview will be conducted in a place convenient to you.

You are requested to spend about 60 to 90 minutes with the researcher in the interview session. You may also withdraw from the study at any point in time. Please note that the responses you share will be kept confidential.

What is the approximate number of participants involved?

Around 30 people from the Rohingya refugee community of Bangladesh living in the camps.

What will be done if I take part in this research?

The researcher will ask a series of questions that will form the basis for the conversation. You will be asked about your experiences as refugees more broadly and the present health experiences of you after coming to Bangladesh. Please answer these questions in any way you and contribute to the responses made by others. If you do not wish to answer a question, simply inform the researcher and

he/she will move on to the next question. You may also withdraw from the study at any point in time. The information gathered from the interview will be used to get a better understanding of Rohingya health in the camps of Bangladesh. You will be asked to complete a short demographic sheet either opening or ending of the interview session.

How will my privacy and the confidentiality of my research records be protected?

Upon your consent, the interview will be audio-recorded for analysis at a later date. No identifiers will be used in the interview in order to protect your identity and only the research team will have access to the data. The raw data will be stored up to the completion of the project.

Excerpts from the audio transcripts will be used in published research articles, but no personal identifiers will be used to link you with your responses. Please note that because the data contains no personal identifiers, it will not be possible to track you down from the interview data, and we will discard your responses once the transcription of the interview is completed.

What are the possible discomforts and risks for participants?

No potential risks are expected for participants in this research. However, if you feel uncomfortable at any point of the interview, you may choose not to answer the question, or even withdraw from the study entirely.

Participants can take the support of friends, whānau (family) or kaumātua (elderly) or local support networks as they deem fit while going through the research (interview) process. This would not require the permission of the researcher team or community researchers. Please note that the researchers are not counsellors or social workers but are willing to assist you, at your request, to make contact with any of the above services or the local service/s.

Will there be reimbursement for participation?

You will be reimbursed 100 (One hundred) BDT (Bangladesh Taka) in cash for participating in the interview.

What are the possible benefits to me and to others?

There is no direct benefit to you from participating in the study, although Rohingya individuals and families living in various countries of the world will benefit from the development of solutions to health that are locally meaningful. The knowledge gained assist in generating solutions that seek to improve health infrastructures, prevention resources, health campaigns, and services and programs.

Can I refuse to participate in this research?

Yes, you can. Your decision to participate in this research is voluntary and completely up to you. You can also withdraw from the research at any time without giving any reasons by informing the Principal Investigator/Researcher. All data collected from you up to that point will be discarded.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study any time;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

Whom should I call if I have any questions or problems?

Please contact the Director, CARE, Massey University, Professor Mohan Dutta, if you have any questions (email: m.j.dutta@massey.ac.nz or phone 021 959 729).

"This project has been carried out in guidance of the Massey University Human Research Ethics Committee (HREC) requirements through which ethical clearance was granted (Ethics Notification - 4000024684)."

Appendix E: Ethics approval from the Massey University

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Date: 02 July 2021

Dear Mahbub Rahman

Re: Ethics Notification - **4000024684** - **Construction of health among the Rohingya refugees in Bangladesh: A Culture-Centered Approach**

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please contact a Research Ethics Administrator.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course -Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:
"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz."

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Appendix F: RRRC approval

Government of the People's Republic of Bangladesh
Office of the Refugee Relief and Repatriation Commissioner
Cox's Bazar
www.rrrc.gov.bd

No: 51.04.2200.006.03.346.2021.5292 Date: 23 December 2021

Sub: Permission for Research work in Rohingya Camps.

Ref: Letter from Md. Mahbubur Rahman, BCS (Information), Deputy Regional Manager, Bangladesh Betar, Chittagong Dated: 21 December 2021

In response to the above mentioned letter, this office is pleased to grant permission for research work in Rohingya Camp area in Cox's Bazar under the following terms and conditions:

1. You are requested to inform before commencing the activities and coordinate while working, with the concerned CiC (Camp-in-Charge);
2. Must follow Govt. Policy, Rules and Laws;
3. Maintain COVID-19 preventive measures;
4. The content/report must be submitted to RRRC office as well as to CiC office, before publishing;
5. You are not allowed to enter the FDMN Camps during Government Holidays.
6. You must leave the Camps before 3.30 pm.

The particulars are as follows:

Activities: Research on- "Construction of health among Rohingyas in Bangladesh."
Camp No: All Camps
Duration: 23 December to 10 January 2022

Please feel free to contact with office if you have any further query.

23/12/21

Md. Shamsud Douza
(Deputy Secretary)
Addl. Refugee Relief and Repatriation Commissioner
Cox's Bazar
Phone: +88 0341-63680

Md. Mahbubur Rahman,
BCS (Information), Deputy Regional Manager
Bangladesh Betar, Chittagong.
Phone: 01716-040213

Copy for Information and necessary action:
01. Camp-in-Charge; All Camps, Cox's Bazar
02. PS to RRRC (For the kind information of RRRC)
03. Office Copy

Appendix G: Statement of Contribution: Chapter 2 (2.2)

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION
DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.

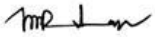
Student name:	Md Mahbubur Rahman
Name and title of main supervisor:	Professor Mohan Dutta
In which chapter is the manuscript/published work?	Chapter 2 (2.2): Term 'Rohingya' accepted worldwide but still taboo in Myanmar
What percentage of the manuscript/published work was contributed by the student?	90%

Describe the contribution that the student has made to the manuscript/published work:

Mahbubur has carried out the fieldwork and pilot study at the Rohingya refugee camps of Bangladesh. He has been working with the Rohingya refugee crisis since 2017. Mahbubur had covered the Rohingya issues as a journalist of the Bangladesh Television (BTV). Currently, he has been interacting with the Rohingya communities in New Zealand as a Research Assistant at the Centre for Culture-Centred Approach to Research and Evaluation (CARE), Massey University. He took the initiative and led the writing of this Academia Letter.

Please select one of the following three options:

√	**The manuscript/published work is published or in press** Please provide the full reference of the research output: Rahman, M. M. (2022). Term 'Rohingya' accepted worldwide but still taboo in Myanmar. *Academia Letters*. Article 5788. https://doi.org/10.20935/AL5788.
	The manuscript is currently under review for publication Please provide the name of the journal:
	It is intended that the manuscript will be published, but it has not yet been submitted to a journal

Student's signature:		Main supervisor's signature:	

This form should be placed at the beginning of each relevant thesis chapter.

Appendix H: Statement of Contribution: Chapter 4 (4.3.3)

MASSEY UNIVERSITY
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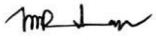
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION
DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.			
Student name:	Md Mahbubur Rahman		
Name and title of main supervisor:	Professor Mohan Dutta		
In which chapter is the manuscript/published work?		Chapter 4 (4.3.3): Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh	
What percentage of the manuscript/published work was contributed by the student?		90%	
Describe the contribution that the student has made to the manuscript/published work: Mahbubur has carried out the fieldwork at the Rohingya refugee camps of Bangladesh. He wrote this article based on his fieldwork experiences and data collection strategies during the fieldwork. He has taken the initiative to write this journal article.			
Please select one of the following three options:			
√	**The manuscript/published work is published or in press** Please provide the full reference of the research output: Rahman, M. M. (2022). Challenges and strategies to conduct research at restricted Rohingya refugee camps of Bangladesh. *Indiana Journal of Humanities and Social Sciences, 3*(9), 22-31. https://doi.org/10.5281/zenodo.7123481.		
	The manuscript is currently under review for publication Please provide the name of the journal:		
	It is intended that the manuscript will be published, but it has not yet been submitted to a journal		
Student's signature:		Main supervisor's signature:	
This form should be placed at the beginning of each relevant thesis chapter.			

Appendix I: Statement of Contribution: Chapter 5 [5.2.1(a)]

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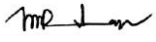
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION
DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.			
Student name:	Md Mahbubur Rahman		
Name and title of main supervisor:	Professor Mohan Dutta		
In which chapter is the manuscript/published work?		Chapter 5 [5.2.1 (a)]: ''Health Means Just to Live'' at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention	
What percentage of the manuscript/published work was contributed by the student?		90%	
Describe the contribution that the student has made to the manuscript/published work: Mahbubur has carried out the fieldwork and pilot study at the Rohingya refugee camps of Bangladesh. He conducted the in-depth interviews, and carried out the data coding. Based on his findings, he led the writing of the manuscript.			
Please select one of the following three options:			
√	**The manuscript/published work is published or in press** Please provide the full reference of the research output: Rahman, M. M. (2023). ''Health Means Just to Live'' at the Rohingya Camps of Bangladesh: A Culture-Centred Intervention. *Global Journal of Addiction & Rehabilitation Medicine, 7*(2): 555710. https://doi.org/10.19080/GJARM.2023.07.555710		
	The manuscript is currently under review for publication Please provide the name of the journal:		
	It is intended that the manuscript will be published, but it has not yet been submitted to a journal		
Student's signature:		Main supervisor's signature:	
This form should be placed at the beginning of each relevant thesis chapter.			

Appendix J: Statement of Contribution: Chapter 5 [5.2.2(a)]

MASSEY UNIVERSITY
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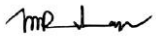
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION
DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.			
Student name:	Md Mahbubur Rahman		
Name and title of main supervisor:	Professor Mohan Dutta		
In which chapter is the manuscript/published work?		Chapter 5 [5.2.2 (a)]: Living through food rations: A culture-centered study with Rohingya refugees	
What percentage of the manuscript/published work was contributed by the student?		80%	
Describe the contribution that the student has made to the manuscript/published work: Mahbubur has carried out the fieldwork at the Rohingya refugee camps of Bangladesh. He has conducted the in-depth interviews, and carried out the data coding. Based on his findings, he led the writing of the manuscript.			
Please select one of the following three options:			
	The manuscript/published work is published or in press Please provide the full reference of the research output:		
√	**The manuscript is currently under review for publication** Please provide the name of the journal: International Journal of Communication		
	It is intended that the manuscript will be published, but it has not yet been submitted to a journal		
Student's signature:		Main supervisor's signature:	
This form should be placed at the beginning of each relevant thesis chapter.			

Appendix K: Statement of Contribution: Chapter 5 [5.2.3(a)]

MASSEY UNIVERSITY
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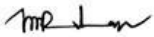
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION
DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.			
Student name:	Md Mahbubur Rahman		
Name and title of main supervisor:	Professor Mohan Dutta		
In which chapter is the manuscript/published work?		Chapter 5 [5.2.3 (a)]: "The beggar's life is better than us": A culture-centered study in Rohingya refugee camps	
What percentage of the manuscript/published work was contributed by the student?		80%	
Describe the contribution that the student has made to the manuscript/published work: Mahbubur has carried out the fieldwork at the Rohingya refugee camps of Bangladesh. He has conducted the in-depth interviews, and carried out the data coding. Based on his findings, he structured and led the writing of the manuscript.			
Please select one of the following three options:			
	The manuscript/published work is published or in press Please provide the full reference of the research output:		
√	**The manuscript is currently under review for publication** Please provide the name of the journal: Communication Monographs		
	It is intended that the manuscript will be published, but it has not yet been submitted to a journal		
Student's signature:		Main supervisor's signature:	
This form should be placed at the beginning of each relevant thesis chapter.			

Appendix L: Statement of Contribution: Chapter 7 [7.5(a)]

MASSEY UNIVERSITY
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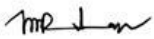
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION
DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.			
Student name:	Md Mahbubur Rahman		
Name and title of main supervisor:	Professor Mohan Dutta		
In which chapter is the manuscript/published work?		Chapter 7 [7.5 (a)]: Rohingya repatriation: various actors need to be considered	
What percentage of the manuscript/published work was contributed by the student?		90%	
Describe the contribution that the student has made to the manuscript/published work: Mahbubur has carried out the fieldwork and pilot study at the Rohingya refugee camps of Bangladesh. He has been working with the Rohingya refugee crisis since 2017. Mahbubur had covered the Rohingya issues as a journalist of the Bangladesh Television (BTV). Currently, he has been interacting with the Rohingya communities in New Zealand as a Research Assistant at the Centre for Culture-Centred Approach to Research and Evaluation (CARE), Massey University. He took the initiative and led the writing of this news article.			
Please select one of the following three options:			
√	**The manuscript/published work is published or in press** Please provide the full reference of the research output: Rahman, M. M. (2022, August 17). Rohingya repatriation: various actors need to be considered. *Refugee Research Online*. https://refugeeresearchonline.org/rohingya-repatriation-various-actors-need-to-be-considered/.		
	The manuscript is currently under review for publication Please provide the name of the journal:		
	It is intended that the manuscript will be published, but it has not yet been submitted to a journal		
Student's signature:		Main supervisor's signature:	
This form should be placed at the beginning of each relevant thesis chapter.			

Appendix M: Statement of Contribution: Chapter 7 [7.6(a)]

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

GRADUATE RESEARCH SCHOOL

STATEMENT OF CONTRIBUTION
DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

We, the student and the student's main supervisor, certify that all co-authors have consented to their work being included in the thesis and they have accepted the student's contribution as indicated below in the Statement of Originality.

Student name:	Md Mahbubur Rahman
Name and title of main supervisor:	Professor Mohan Dutta

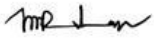
In which chapter is the manuscript/published work?	Chapter 7 [7.6 (a)]: Statelessness – the Root Cause of the Rohingya Crisis – Needs to Be Addressed
What percentage of the manuscript/published work was contributed by the student?	90%

Describe the contribution that the student has made to the manuscript/published work:

Mahbubur has carried out the fieldwork and pilot study at the Rohingya refugee camps of Bangladesh. He has been working with the Rohingya refugee crisis since 2017. Mahbubur had covered the Rohingya issues as a journalist of the Bangladesh Television (BTV). Currently, he has been interacting with the Rohingya communities in New Zealand as a Research Assistant at the Centre for Culture-Centred Approach to Research and Evaluation (CARE), Massey University. He took the initiative and led the writing of this article following a call for paper by the American think-tank.

Please select one of the following three options:

√	**The manuscript/published work is published or in press** Please provide the full reference of the research output: Rahman, M. M. (2023) (Accepted). Statelessness – the Root Cause of the Rohingya Crisis – Needs to Be Addressed. *New Lines Institute for Strategy and Policy, USA*.
	The manuscript is currently under review for publication Please provide the name of the journal:
	It is intended that the manuscript will be published, but it has not yet been submitted to a journal

Student's signature:		Main supervisor's signature:	

This form should be placed at the beginning of each relevant thesis chapter.