

Research Article

Exploring Mental Health Status and Psychosocial Support among Rohingya Refugees in Bangladesh: A Qualitative Study

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Objectives. Decades of targeted violence, statelessness, and persecution have caused more than a million Rohingyas to flee their homes to Bangladesh. Although basic assistance is being provided, these refugees are living in highly challenging circumstances. The burden of mental health among these refugees is believed to be widespread; however, the extent of these problems is yet to be fully ascertained. We, therefore, conducted a qualitative study to explore the mental health status and psychosocial support among the Rohingya refugees. **Methods.** A participatory, qualitative research was conducted among the Rohingya refugees, guided by a multidisciplinary team of experts. A mix of purposive sampling, snowball sampling, and random sampling techniques was applied. The participants were randomly selected to ensure the representation of vulnerable groups and physically disabled people. Data were collected by using pretested semi-structured questionnaire and a health facility assessment checklist. The data were analysed using SPSS (version 24) and thematic content analysis techniques. **Results.** There is a high prevalence of mental health and psychological problems among the Rohingya refugees, but most of the problems are hidden or remained unnoticed. Daily stressors were found to be widespread and associated with social insecurity, lack of livelihood opportunities, and past trauma history of the participants. **Conclusions.** Stigma and cultural interpretation of mental health among Rohingya are unique and are different from the host population of Bangladesh. To address such huge and challenging problems, all partners working in the humanitarian assistance and development programs in Bangladesh need to provide integrated, effective, and culturally appropriate services to the Rohingya population.

1. Introduction

Rohingyas—an ethnic and religious minority of Rakhine State—have long been subject to unspeakable suppression and atrocities from the Myanmar authorities [1]. These Rohingya populations were stripped off their citizenship rights, forcing them to live as stateless citizen within their own country. In addition, there were serious discrimination, marginalization, and denial of their enjoyment of basic human rights, which led to repeated mass migration to Bangladesh [2]. Since August 2017, there have been further

escalation of violence and suppressive activities in the Rakhine State, which resulted in massive exodus of nearly a million of Rohingya population into Bangladesh. They joined to >200,000 residual Rohingyas who are already living in two megacamps in the south-east district Cox's Bazar [3, 4].

Despite the remarkable efforts from the Government of Bangladesh, United Nations, and their partners, the majority of the Rohingya refugees are still living in desperate and overcrowded conditions. Makeshift life in camps poses challenges to their cultural, religious, and gender norms,

traditions, and identities. Although the basic health services are generally adequate and well-organized, the mental health and social care services are quite rudimentary [4]. Consequently, the mental health and psychological conditions among refugees remained unaddressed, rather they continue to deteriorate further. These limitations of mental health and psychosocial support (MHPSS) services are making the refugees psychosocially vulnerable and putting extra pressure on their already unstable minds [4].

It is widely acknowledged that people feel overwhelmed, confused, and distressed when they are displaced from their own settings [5, 6]. They generally feel extreme fear and worries, emotional outbursts such as anger and sadness, and sleep problems including nightmares. They may also have nervous breakdown and loss of cognitive capacities and therefore may become incapable to deal with the dangers and risks they face. Studies also suggest that the prevalence of health problems related to extreme stress, such as posttraumatic stress disorder (PTSD), is higher in refugees than in the general population [7, 8].

For Rohingyas, there is no end to the crisis in sight, and therefore, further deterioration of mental health and the psychosocial situation is expected. Although there are general health and protection services available from the UN and development partners, the actual need for mental health and psychological support (MHPSS) has not been properly addressed. This study, therefore, is aimed at gaining a better understanding of mental health status and psychosocial support among the Rohingya refugees in order to provide evidence for an appropriate, long-term MHPSS program for these refugees. We undertook a well-planned, qualitative study to accomplish the research objectives.

2. Methodology

2.1. Study Design and Approach. The study design was conceptualized within the framework of a theory of change [9] to get clarity on the process and to focus on future programming. More specifically, this study was designed to capture the mental and psychosocial issues which were the manifestations of the experience of violence, conflicts, and trauma in order to provide evidence from the field for future programming on MHPSS for the refugees.

A participatory, community-based approach was used, guided by a multidisciplinary team having expertise in mental health in conflict settings. The contextual understanding was underpinned by the Inter-Agency Standing Committee (IASC) guidelines on mental health and psychosocial support in emergency settings, Mental Health Gap Action Program (mhGAP), and PM+ (problem management+) and UNHCR's accountability framework for age, gender, and diversity concerns [2, 10–14].

The study design encompassed the following 3 (three) steps: it started with a comprehensive desk review, followed by the data collection in the field to assess the current delivery and uptake, and quality of essential health services for the Rohingya refugees (step 2), which included (a) inception meetings with key stakeholders in Dhaka and Cox's Bazar, (b) meetings with senior staff and incident management

leads at WHO Cox's Bazar before and after the commencement of fieldwork in order to fine-tune processes, and (c) data collection through health facility assessment questionnaires, focus group discussions (FGDs), key informant interviews, and nonparticipant observation of health services and its providers at the facilities in the camps. Step 3 included analysis triangulation and validation leading to conclusions and recommendations.

2.2. Setting. The study was conducted in randomly selected refugee camps in Cox's Bazar district. There are a total of 34 refugee camps of various sizes, geographically located in two subdistricts (Teknaf and Ukhiya Upazila) of Cox's Bazar. Over 1.1 million Rohingya refugees are residing in these camps, among them, 625,000 refugees live in two mega camps known as Kutupalong and Balukhali expansion sites.

2.3. Sampling Frame and Study Participants. A mix of purposive sampling, snowball sampling, and random sampling techniques was applied. Purposive sampling took into account key data and inequity dimensions reported from the field. In order to reach sufficient coverage of hospitals, we purposively covered 4 hospitals: the only district hospital located in Cox's Bazar, two Upazila health complexes (Teknaf and Ukhiya), and one randomly selected field hospital. For primary healthcare centres and healthcare posts, we randomly selected 50 facilities using the latest list of health facilities provided by the WHO office, Cox's Bazar. From an equity standpoint, the sampling frame took into account geographical location as well as national and international organizations managing the health post. In addition, gender, types of services (specialist and general/comprehensive), and population in the service area were taken into account. Since the majority of the population resides in two mega camps, Kutupalong and Balukhali, we purposively oversampled in these areas, while also selecting health posts from lesser populated areas to reach sufficient coverage. As there are 24 zones in the total camp, we selected 3–4 healthcare posts (oversample) in the two mega camps that contain the bulk of the population.

The interviews with the key partners involved in care delivery for the refugees were discussed/decided on with MOH and WHO. We also conducted in-depth interviews with the different actors/agencies and FGDs with Rohingya participants. The list of primary healthcare (PHC) facilities inside the camps was collected from the government and WHO, and then, the PHC facilities were selected by using simple random sampling from the facility list. Farther facilities were purposively selected to ensure the inclusion of all important facilities at tertiary and secondary levels. The FGD participants were selected purposively based on discussions with the key informants, WHO, and the government-run coordination offices in Cox's Bazar.

In order to get deeper insights into mental health and psychosocial needs, we selected participants from both service providers and community members. An initial mapping of the MHPSS service providers was conducted prior to the selection of the participants. The service providers were then randomly selected from the mapping list through a snowball

sampling to dig deeper into their needs, experiences with health care, perceptions on service provision regarding the MHPSS, and the gaps in MHPSS services. The community members were also randomly selected covering all geographical settings of the refugee camps. Efforts were made to ensure the representation of vulnerable groups including young women, adolescents, and physically disabled people. We also ensured diverse composition of the FGDs, including male and female caretakers and adults of different ages.

2.4. Data Collection and Management. A desk review was performed as part of understanding the context of mental health among the Rohingya refugees. Data were collected by using pretested tools such as a semi-structured questionnaire, health facility assessment (HFA) checklist, observation checklist, and thematic FGD guide. These tools were translated into the local Bangla language. The key members of the research team could understand and speak the Bangla language very well. However, during the interviews and FGDs with the refugee participants, we included local health managers or community members with the ability to understand and speak in the Rohingya dialect who facilitated interviews/discussions and interpreted the language to the core research team members.

The field data collection started with a meeting with the key stakeholders at the regional level. The health facility assessment and observation checklists were administered at every facility visited according to the random sampling frame. The topics for direct observation were whether there was a visible signboard outside the centre and were there any clients for MHPSS services waiting and the general cleanliness of the facility. The interviews were conducted by the research team supported by locally trained data collectors specifically hired for this study. Disaggregated data was collected from different groups (age, sex, ethnicity, religion, place of occurrence of trauma or violence (home, school, education, and workplace), and people living with disabilities). Verbal informed consent was obtained before every interview and discussion. Respondents were interviewed to get deeper insights into their perceptions of service provision for mental health and psychological problems and the quality of care received in the health centres, as well as the perceived accessibility of health services.

2.5. Data Analysis. A step-wise process was used to analyse the data. We used this approach to accomplish the analysis, ensuring to answer all questions as outlined in the scope of the study. As some of these steps were applied simultaneously, a preliminary analysis was initiated while still collecting field data. At the end of each day, the research team reviewed the data collected from the interviews. This process helped to refine the questions for future data collection plans or to change the type of questions where necessary. We also analysed data periodically to monitor the quality of data and to track the missing data. During this staggered analysis, we developed some general themes for future coding and thematic analysis. The qualitative data from semi-structured interviews and FGDs were analysed using thematic content analysis techniques. The quantitative data from the facility

assessment were analysed using SPSS (Statistical Package for the Social Sciences) (version 24). The information about the MHPSS services was collected through the HFA checklist and was analysed under the following categories: types of health facility, types of implementing agencies, number of technical staff (e.g., MHPSS), whether protocols were on-site, and whether supportive supervision was received in the past month.

3. Results

3.1. Data Collection Tools and Demographic Characteristics of the Participants. Table 1 describes the types of data collection methods used, the number of interviews and FGDs undertaken, and the demographic characteristics of the participants.

3.2. Mental Health and Psychosocial Issues. The majority of the interviewees reported mental health concerns such as explosive anger, psychotic-like symptoms, psychosomatic, impaired functioning, and suicidal ideation. Many adult respondents reported “not feeling well,” “always thinking of the future,” “sad and tense,” “and cannot sleep at night.” Other symptoms included loss of appetite and frequent health complaints of unexplained nature. Almost two-thirds of the male respondents said they were constantly thinking about the uncertainty about their citizenship and the fate of their lives once they go back to Myanmar. The key MHPSS issues of the needed assessments, derived from the qualitative data (interviews and discussions), are given below.

3.2.1. Daily Stressors. Daily stressors among Rohingya refugees were widespread and associated with social insecurity, lack of livelihood opportunities, and their past trauma history. The majority of the respondents reported the presence of daily stressors associated with their camp life, including problems with food, sanitation, and fresh water and concerns regarding personal safety. One female interviewee mentioned: “We don’t get sufficient food now. Also, the weather is too hot and it’s difficult to stay in a small place. How can I stay in peace? How can I remain without stress?” [Age: 60. Female, Rohingya Refugee].

Unemployment, family conflict, the burden of childcare, physical illness, financial crisis, and coping with “new people” were factors considered to be increasing stress in daily life. When asked, the young women and adolescents revealed symptoms like sadness, low mood, lack of interest in daily activities, and anxiety. On the other hand, male respondents mentioned excessive anger and irritation in their day-to-day interactions.

3.2.2. Conflicts in Daily Life. Daily life conflict with the husband and other family members was the main trigger of mental depression. Other daily living difficulties included restricted movement, lack of access to business or financial opportunities, safety and protection issues, lack of healthcare services, and inadequate shelter conditions. An adult male respondent said: “I used to work in a school and I had a good income, a good house with bathroom; but look at here what

TABLE 1: Types of tools used and general demographic characteristics of the participants.

Type of data collection method and tools	Number of interviews, FGD/HFA questionnaires completed (<i>n</i>)	Gender
Health facility assessment (HFA) checklist ¹	23	
Key informant interview (service providers) ²	12	Adults: 8 female, 4 male
Key informant interview (clients) ³	15	Adults: 10 female, 5 male
Observation checklist ⁴	19	
Focus group discussions (FGDs) ⁵	4	Adults: female : male ratio—50 : 50

¹HFA checklist was administered at every facility visited as part of the random sampling frame. ²Key informant interviews for service providers were done after the mapping of facilities. ³Interviews of clients and key informants were conducted at the camps. ⁴Observation checklists were administered as part of field visits through both random and purposive sampling to make in-depth observations of health services focused on MHPSS [15]. ⁵FGDs were conducted in the camps and at Cox's Bazar based on FGD guide which centred on the MHPSS.

I have; 10 people staying in one small hut” [Age: 46, Male, Rohingya Refugee].

3.2.3. Flashback of Past Events. The stressful events that happened back home in Myanmar caused nightmares and flashbacks among the majority of the study participants. One interviewee vividly remembered: “Army attacked our village and they threw my brother’s little child in front of me....then killed my brother and her wife. I came without borkha (a special dress of Muslim women). I felt so guilty. Still, I am feeling guilty that I came almost necked” [Age: 50, Female, Rohingya Refugee].

This topic was discussed with the community leaders locally known as *Majhis*. When asked to make a list of events from their past life (in Myanmar) that they thought had had effects on their mental state, they mentioned the destruction of their houses by the army, physical torture and beatings, forced labour, and frequent arrests. They also mentioned suppressive activities by the local thugs.

3.2.4. Identity Crisis. When asked about their personal identity, the vast majority of female respondents mentioned that they felt helpless and angry because they had to leave their own homes back in Myanmar and were forced to live at the mercy of others. They felt that it was disrespectful as well. During the group discussions, one participant expressed her frustration: “You and your children have got your own country. What about my children? They are stateless....they do not have any country” [Age: 50, Female, Rohingya Refugee]. Another participant reflected on their camp life: “We are staying here but this is not my country. I feel suffocated when I think that” – [Age: 55, Female, Rohingya Refugee].

3.2.5. Anticipatory Anxiety. Many respondents were anxious about their uncertain future. They were concerned about so-called repatriation (or pushback), education of the children, housing, and employment. Lack of any future prospects and poor living conditions, dependency on food and livelihood, obstacles to pursuing any business, and high levels of domestic violence also impacted on their mental health. A female respondent told the research team: “When I hear about going back to Myanmar, I feel anxious. What will happen there? Will there be torture again? I can’t simply

sleep when I think about those issues” [Age: 60, Female, Rohingya Refugee].

During group sessions with female refugees, the participants also mentioned the psychological impacts due to settlements in unknown surroundings. One female participant mentioned: “I do not get good sleep; I always have bad dreams every night. Although we are better here; we don’t know what is in our luck in the future” [Age: 53, Male, Rohingya Refugee].

3.2.6. Social Anxiety. The interviewees stated that social cohesion and support were almost absent within the camps. The preexisting social structure, which they had in Myanmar, was not maintained. The family members have been lost or separated due to death from violence in Myanmar or during the mass exodus or strenuous journey to cross the border to Bangladesh. Consequently, there were many families with a single female member who felt threatened and vulnerable in the camp settings. Also, male respondents expressed their loneliness. One elderly male refugee said: “My wife and the only young son died, my life is shattered. I am alone now; how I can live without them” [Age: 80, Male, Rohingya Refugee].

3.2.7. Gender-Based Violence (GBV). It was found that most female respondents did not want to talk openly about sexual violence and abuse. When asked, they referred to gender-based violence (GBV) including rape as “shameful” incidents and they did not want to disclose them. However, one elderly female said: “...of course, we are aware of those incidents” [Age: 65, Female, Rohingya Refugee].

Interviews with female refugees revealed a high prevalence of multiple marriages, beating and torturing the wives, getting married without legal paper, and getting pregnant before marriage all were associated with depression, restlessness, and anger. One female respondent said: “My husband got married to a lady from another camp. Now he doesn’t come to me and doesn’t take care of my children” [Age: 50, Female, Rohingya Refugee].

3.3. Cultural Concepts around MHPSS and Help-Seeking Behaviour. During the health facility assessment, most of the doctors mentioned that they saw many patients who did not have any specific disease or symptom. The patients attending their clinic were unsure about their physical

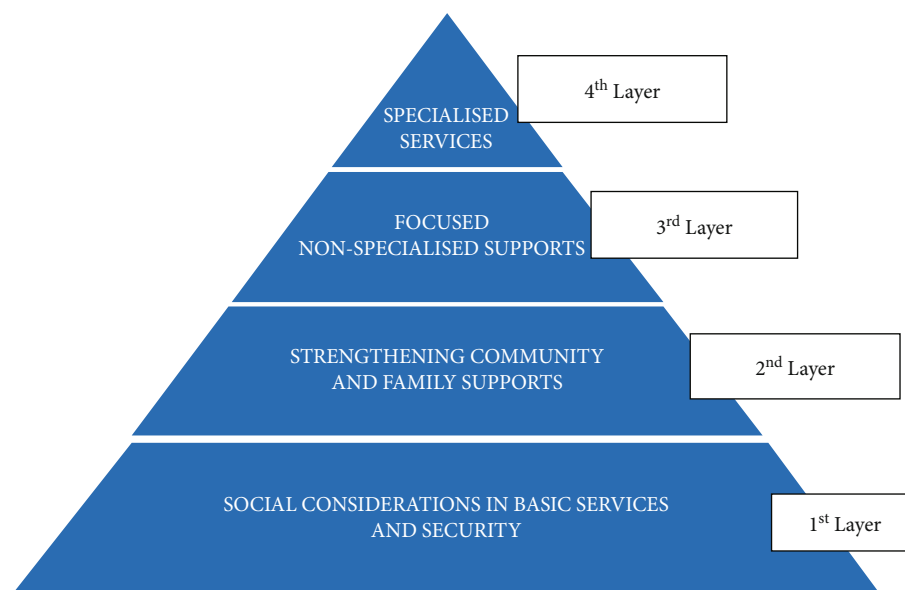


FIGURE 1: IASC pyramid of multilayered MHPSS services.

complaints. When further explored, it was found that the Rohingyas had their own words and descriptions of health and emotions, which were different from the western-oriented approaches. The majority of the program managers also agreed that this issue is a key factor to remember while designing the MHPSS interventions. They suggested including these terms in the training of the MHPSS service providers who would be recruited to work at the refugee camps.

In terms of help-seeking behaviour, we found that the refugees were dependent on traditional healing methods when treating mental health problems. Moreover, the Rohingyas did not seek help for their mental health problems due to limited familiarity with mental health services within the camps. In addition, the stigma and beliefs about mental health problems were big obstacles in seeking care. However, some refugees were motivated to seek mental healthcare support from community-based counsellor selected from their own community.

3.4. MHPSS Services in the Camps. The Inter-Agency Standing Committee (IASC) guidelines on mental health and psychosocial support in emergency settings [15] were used to assess the MHPSS services (Figure 1). We found that WHO is working with the civil surgeon (health chief at the district level) to enhance the capacity of the nearby Upazila health complexes to manage mental health conditions who were referred from the camps. There was an MHPSS working group to coordinate the MHPSS services at the field level.

At the camp level, there were activities/services to address the MHPSS problems provided through primary healthcare centres (PHCs) but were limited. The MHPSS activities included the following: (i) individual sessions for the clients on stress management, anger management, PTSD, depression, and self-esteem, (ii) group sessions for women and adolescents girls, (iii) psychological first aid (PFA) sessions for the community people, (iv) capacity

building training for the staff, (v) piloting of IAT (integrated adapt therapy), (vi) IASC and MHPSS training for the service providers, and (vii) community visits and group sessions services organized by the field counsellors.

The members of the MHPSS working group reported that over twenty NGOs were providing MHPSS in the camps. 150 doctors and health service providers attended some capacity building activities especially on psychological first aid training, WHO Mental Health Gap Action Program (mhGAP), and on basic counselling skills. We found that in many PHCs, the MHPSS counselling including individual sessions with adolescent boys and girls was conducted by the general health service providers.

Some NGOs were found to run various recreational activities in their health centres conducted by para-counsellors who were trained in basic psychosocial skills. Supervision was done either by face-to-face visits or via cell phone calls. One female para-counsellor said: “It’s difficult to meet face-to-face with adolescent and unmarried girls. They are not inclined to come to the centre. However, regular home visits helped me to bring the clients to my centre. Of course, I got help from other staff such as nutrition workers and health workers to reach the clients” – [Age: 38, Female, Rohingya Refugee].

Community people were informed about mental health services through home visit by community volunteers. At least 4 NGOs had some form of community-based MHPSS activities. We found that the Rohingyas were sensitive about the gender and religion of the MHPSS service providers and paracounsellors. One non-Muslim female counsellor told: “Rohingya women are very conservative in their culture. It takes time to establish rapport.” As one female community volunteer revealed, “They always ask about my religion. I always skip the topic technically. Whenever they ask me if I am a Muslim or not, I usually keep quiet. I just say ... hmmm...because it may hamper my rapport with my client.”

In the registered refugee camps, UNHCR had piloted some MHPSS interventions, in which key components were strengthening self-help mechanisms at the community level through work with religious leaders and community leaders and awareness-raising activities around of psychological well-being and coping skills.

During the facility assessment, two randomly selected child protection centres were visited. It was found that the facilitators were running group sessions where they were providing psychosocial support through mindfulness exercises, positive appreciation, and story-telling activities. Moreover, the refugees had access to free health care and a degree of legal protection. However, legal protection and access to health services were very limited in “nonregistered” makeshift camps.

During the facility visits, it was observed that most health or protection facilities were run by young staff with little experience in the medical or mental health field. A vast majority of medical doctors were just graduated from medical colleges and often had no practical experiences. The senior program managers were aware of these shortcomings but faced challenges in recruiting experienced staff due to the remoteness of the camps and poor transport communications. In addition, there was a high turnover of staff, specifically the medical and technical staff. Some female MHPSS counsellors did not want to work in the camps due to security concerns. One female counsellor told: “We always leave the camp early so that we can return to Cox’s Bazar before dark. Some of my friends left their job because they didn’t feel safe in the camps. The travel from Cox’s Bazar to camps and back is very tiring” [Age: 30, Female, Mental Health Counsellor].

There were a considerable number of organizations who were involved in providing psychosocial support to the Rohingya. However, there was a lack of coordination among those organizations in regard to MHPSS services.

4. Discussion

Almost all participants experienced at least one incidence of violence or torture before fleeing from their country. However, the vast majority of respondents had multiple episodes of extreme forms of physical abuse including loss of family members and assets. The reported mental symptoms among the participants who had a past history of violence were invariably present. We observed a pattern of expression of generally described symptoms: the tendencies of women to show internalizing disorders (e.g., depression and anxiety) compared to men showing externalizing disorders (e.g., anger, alcohol, and behavioural problems). We also found that mental health and psychosocial manifestations among the Rohingya refugees are associated with daily stressors as well to their past traumatic experiences. Our data indicate the presence of a wide range of mental health concerns. While analysing the typical symptoms of mental health and psychosocial disorder, these were found to be similar to symptoms associated with common mental disorders (CMDs) like depression and anxiety, as well as post-traumatic stress disorders (PTSDs). These study results

corroborate the growing body of literature showing the association of traumatic events and daily stressors with mental health outcomes and also contribute to the existing knowledge base of mental health status in various refugee settings [5, 6, 16].

The prevalence of stressors in refugees was obvious and was largely related to the restrictive humanitarian context with a lack of privacy, a lack of freedom of movement, and a lack of access to basic services. This result is consistent with the findings of a study among refugees in Israel [17, 18]. It was evident that the levels of emotional distress were very high, especially among young women and adolescents.

Despite the wide range of estimates reported by the service providers, the findings of this study strongly suggest that mental health and psychological issues constitute a big public health concern among the Rohingya communities. The study confirms the previous estimates and perceptions about MHPSS problems and services reported by other authors [6, 19]. Although the study findings revealed a high prevalence of MHPSS problems among the refugees, most of the problems were untold or remained unnoticed. It is probably due to their sociocultural norms to the low level of awareness about mental health. Stigma and cultural interpretation of mental health among Rohingyas were found to be different from that of host communities. This finding is consistent with the findings of a previous review of studies among refugees [19, 20].

There were a limited number of agencies—mainly the NGOs, who are providing MHPSS services in the camps. The health service providers felt that all partners (government and development partners) working in the humanitarian sector need to provide integrated and culturally appropriate services in order to address such huge and challenging problems. However, an overarching issue in providing such integrated services is to encourage a well-coordinated, public-private-donor collaboration, and multisectoral approach.

While reviewing the MHPSS services, we observed that the service providers were aware of the IASC’s pyramid of four-layered MHPSS services (Figure 1), but in practice, these were not well-structured and followed accordingly.

The research team explored the recommendations for the provision of effective MHPSS services in the camps. Social considerations at the basic services and strengthening the community-based support system (Figure 1: 1st and 2nd layers) are the most crucial considerations for further attention in the context of the humanitarian-development nexus. The PHCs can play a vital role to integrate community-level, nonspecialized psychosocial support services such as psychological first aid (PFA) for vulnerable groups to maintain their mental health and psychosocial well-being (3rd layer).

The specialized services (i.e., 4th layer activities) can be organized at the district hospital. However, access and utilization of such services would be challenging due to the long travel from the camps. Moreover, the referred patients require special permission to leave the camps, the process of which is cumbersome and time-consuming. The service providers also felt that the MHPSS services should be

developed based on the internationally agreed strategies and policies.

The community-based services such as lay counselling and relaxation exercises can be provided through trained community volunteers as part of the basic psychosocial services. Specific refugee support groups can also be created to provide effective psychosocial support interventions. Since mental health problems are often related to stigma, these refugee support groups can provide culturally accepted interventions to deal with the mental health issues.

This study identified the need to strengthen the vertical and horizontal synergies between the organizations, providers, and the health centres. Among the key factors for developing effective MHPSS programs are strong leadership and commitment by governments, the involvement of relevant stakeholders, evidence-based actions, explicit attention to the human rights of people with mental disorders and psychosocial disabilities, and the protection of vulnerable and marginalized groups. This study also highlighted the need to strengthen the service provision for mental health and to strengthen the health system, taking a more developmental approach.

The main limitations were the restriction of movement in and out of the camps. Researchers could not use the full day in the camps; i.e., we had to leave the camps much earlier so that we could reach our base in Cox's Bazar before the sunset (which is the policy of the government and UNDSS). There were challenges in organizing group sessions due to security concerns. Moreover, there were a few venues that were considered "private" and "safe" for the participants. Observation bias may likely be there.

5. Conclusion

Rohingya refugees are facing a huge burden of mental health and psychosocial problems that need immediate attention. We found that Rohingya refugees were not comfortable discussing openly with the people of different sexual orientations vis-à-vis their mental health issues. The study recommends strengthening mental health services in accordance with the IASC's pyramid of multilayered MHPSS service framework. At the same time, the study urges improved resources and capabilities to financially and technically reinforce the Government of Bangladesh's development agenda for better mental health and psychosocial support services and coordination.

Data Availability

The data used to support the findings of this study are included within the article and further data are available from the corresponding author upon request.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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