

Psychosocial support for Rohingya young people living in Bangladesh

Midline evidence from GAGE

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Introduction

Addressing refugees' needs for psychosocial support has become a critical part of the global response to humanitarian crises and is integral to the United Nations' approach to safeguarding the protection and well-being of displaced populations (United Nations High Commissioner for Refugees (UNHCR), 2019; International Organization for Migration (IOM), n.d.). Displaced populations often suffer from trauma due to armed conflict, persecution or disaster, as well as the wide-ranging hardships they face in host environments, especially in camp settings. These elements compound to create significant psychological pressure on displaced individuals, families and communities. The United Nations Children's Fund (UNICEF) posits that prolonged and protracted conflict and situations of mass displacement – as in the case of the Rohingya population living in Bangladesh – present especially challenging conditions for child and adolescent mental well-being, and catalyse increased anxiety, depression and stress (UNICEF, n.d.). In addition, the Covid-19 pandemic exacerbated threats to mental health globally, with children and adolescents particularly susceptible to a multitude of negative mental health outcomes as a result of the

pandemic and related containment measures (Samji et al., 2021). There is evidence of this among the adolescent Rohingya population living in camps in Cox's Bazar, Bangladesh. Adolescents experienced anxiety during the pandemic due to limited virus testing, high potential for the virus to spread (due to camp overcrowding), and even more limited health service uptake (Guglielmi et al., 2020c; Seager et al., 2023).

An estimated 930,000 Rohingya live in 33 congested camps across Cox's Bazar, constituting the largest refugee settlement in the world, and more than 75,000 Rohingya have been relocated to Bhasan Char island, reachable only through approved military transit (Inter-Sector Coordination Group (ISCG) et al., 2024). It is now seven years since the Rohingya fled their homes in Myanmar and arrived in Cox's Bazar. The protracted nature of the crisis, the categorisation of the Rohingya by the Government of Bangladesh as 'forcibly displaced Myanmar nationals' (FDMNs) rather than refugees (thereby preventing them accessing refugee-specific rights), and recent aid cuts¹ all add complexities to the humanitarian response (Pirovolakis, 2023; United Nations (UN), 2023).



Two adolescent girls, 12 and 11, with an umbrella in a Rohingya camp, Bangladesh © Nathalie Bertrams/GAGE 2024

¹ Commitments by United Nations (UN) Member States to the Rohingya humanitarian appeals have fallen from approximately 70% in 2021, to 60% in 2022 and around 30% by October 2023. There have been significant cuts in food aid: in mid-2023, the UN World Food Programme (WFP) cut per person food rations from US\$12 to US\$8, and although still inadequate they were increased to only US\$10 in January 2024.

This report, which draws on mixed-methods data collected in 2023 as part of the Gender and Adolescence: Global Evidence (GAGE) research programme, aims to contribute to efforts by the Government of Bangladesh and its humanitarian partners to strengthen evidence-informed approaches to services to support young people's psychosocial well-being. We begin by introducing GAGE's conceptual framework, and then briefly review earlier GAGE findings on psychosocial well-being in the Rohingya camps of Cox's Bazar and Bhasan Char. We then present our methodology and findings from midline data collection, before concluding with recommendations for policy and programming.

Context

Cox's Bazar is among the most impoverished regions in Bangladesh and currently hosts close to 1 million displaced Rohingya whose mental health and psychosocial needs remain acute. In a large cross-sectional study of the Rohingya in Cox's Bazar, 87% of participants reported having experienced at least one traumatic event and 30% had experienced depressive symptoms (Ritsema and Armstrong-Hough, 2023). A separate survey among 495 randomly selected Rohingya adults showed that almost all participants had been exposed to gunfire (99%) and/or had witnessed dead bodies (92%); more than half (56%) had been subjected to torture and a third (33%) had experienced sexual assault (Riley et al., 2020). Literature suggests that exposure to such trauma can result in serious mental health problems. Almost two-thirds (61%) of Rohingya adults showed symptoms of post-traumatic stress disorder (PTSD) and 84% demonstrated levels indicative of emotional distress (symptoms of anxiety and depression) (ibid.).

In Bangladesh, however, mental health is accorded low priority among policymakers and represents only 0.44% of the country's total health budget (Tarannum, 2019). Although the humanitarian response has mobilised to provide mental health and psychosocial support (MHPSS) services to displaced Rohingya and surrounding host communities, with commitment and joint efforts between the Government of Bangladesh, UN agencies and national as well as international non-governmental organisations (NGOs), significant gaps remain. These gaps include a lack of mental health facilities, and a lack of trained personnel who are capable of working with mentally distressed children and adolescents (Elshazly et al., 2019; Islam and

Mozumder, 2021; Islam and Naing, 2023). Additionally, camp services have been considered to be overly aligned with Western concepts of psychosocial disorders that do not easily translate into the Rohingya culture, and remain unable to redress notions of stigma when discussing mental health, or seeking care (Tay et al., 2019; Ullah et al., 2023).

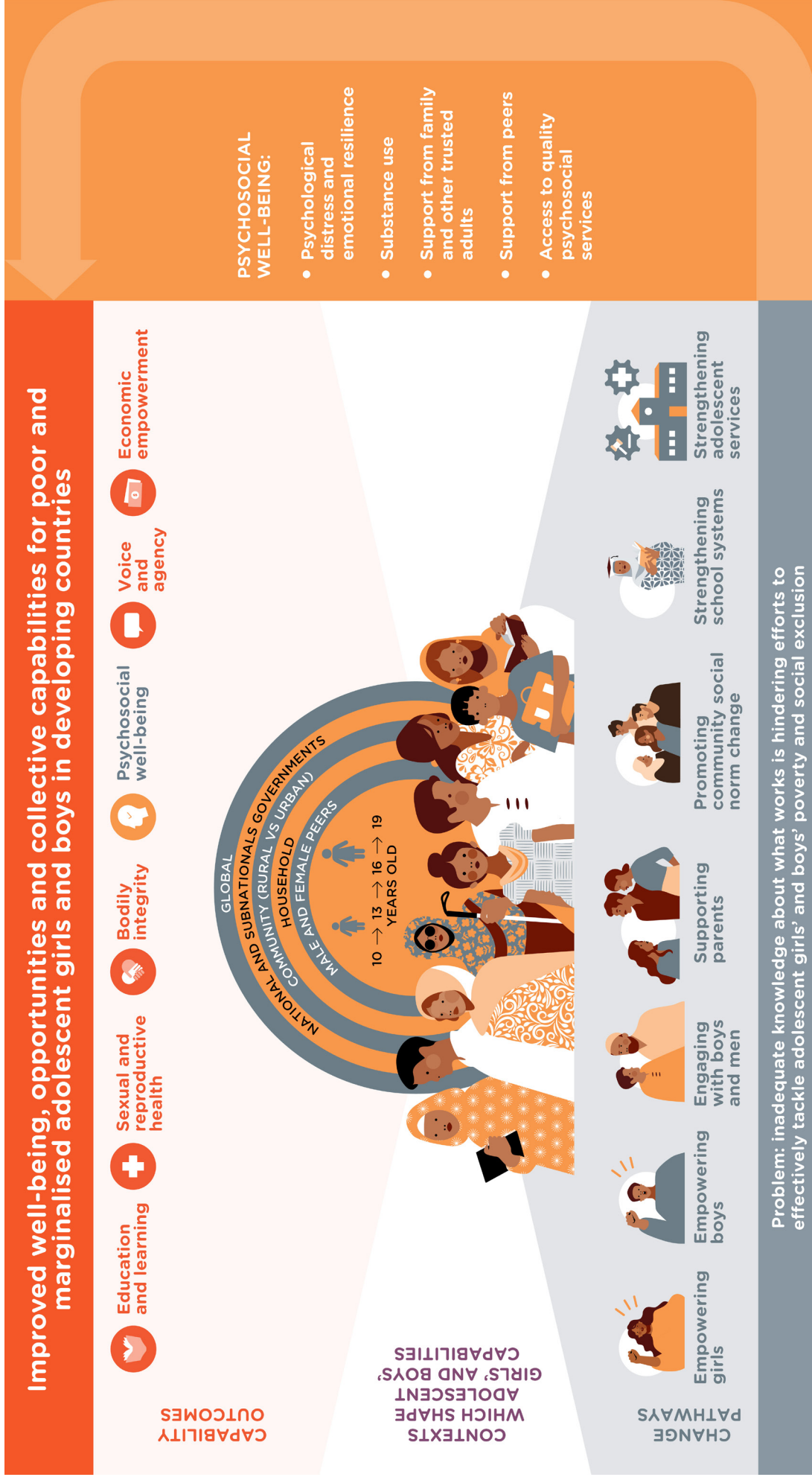
Although MHPSS services sit within the remit of the health sector, the multi-sectoral nature of MHPSS – particularly for children and adolescents – reflects the need for an integrated approach to service provision. The MHPSS Working Group in this context acts as a multi-sectoral bridge between health, protection, nutrition and education sectors in particular, offering a range of interconnected services and coordination mechanisms (Elshazly et al., 2019). MHPSS integrated services in this context may include: community-based psychosocial interventions; clinical mental health services; psychosocial support and counselling in protection spaces (such as women-friendly spaces); and the training of community psychosocial volunteers and mental health counsellors to help increase the understanding of mental health concerns and amplify existing psychosocial support services and programmes (UNHCR, 2022).

Conceptual framing

Informed by the emerging evidence base on adolescent well-being and development, GAGE's conceptual framework takes a holistic approach that pays careful attention to the interconnectedness of what we call the '3 Cs' – capabilities, change strategies and contexts – in order to understand what works to support adolescents' development and empowerment, both now and in the future (see Figure 1). This framing draws on the three components of Pawson and Tilley's (1997) approach to evaluation, which highlights the importance of outcomes, causal mechanisms and contexts, though we tailor it to the specific challenges of understanding what works in improving adolescents' capabilities.

The first building block of our conceptual framework is capability outcomes. Championed originally by Amartya Sen (1985, 2004) and nuanced by Martha Nussbaum (2011) and Naila Kabeer (2003) to better capture complex gender dynamics at intra-household and societal levels, the capabilities approach has evolved as a broad normative framework exploring the kinds of assets (economic, human, political, emotional and social) that

Figure 1: GAGE conceptual framework



expand the capacity of individuals to achieve valued ways of ‘doing and being’. At its core is a sense of competence and purposive agency: it goes beyond a focus on a fixed bundle of external assets, instead emphasising investment in an individual’s skills, knowledge and voice. Importantly, the approach can encompass relevant investments in children and young people with diverse trajectories, including the most marginalised and ‘hardest to reach’ such as those with disabilities or those who were married as children. Although the GAGE framework covers six core capabilities, this report focuses on psychosocial well-being. It explores young people’s psychological distress and emotional resilience, access to peer networks and supportive adults, substance use, and access to psychosocial support services.

The second building block of our conceptual framework is context dependency. Our ‘3 Cs’ framework situates young people socio-ecologically. It recognises that not only do girls and boys at different stages in the life course have different needs and constraints, but also that these are highly dependent on their context at the family/household, community, state and global levels. In the case of psychosocial well-being, cultural contexts and deeply entrenched gender norms are a key factor, as are the contours of the educational and health care systems and the labour market.

The third and final building block of our conceptual framework – change strategies – acknowledges that young people’s contextual realities will not only shape the pathways through which they develop their capabilities but also determine the change strategies available to them to improve their outcomes. Our socio-ecological approach emphasises that to nurture transformative change in girls’ and boys’ capabilities and broader well-being, change strategies must simultaneously invest in

integrated intervention approaches at different levels, weaving together policies and programming that support young people, their families and their communities while also working to effect change at the systems level. This report concludes by reflecting on what type of package of interventions could better support Rohingya young people’s psychosocial well-being.

Sample and methods

This report draws on midline data collected in 2023 as part of the GAGE longitudinal research programme, which explores what works to support the development of adolescents’ capabilities as they transition through adolescence and into young adulthood (GAGE consortium, 2019). Quantitative data collection took place from July to October 2023, with additional tracking in December 2023 and January 2024. Qualitative data was collected in March and April 2023. Research was conducted in 24 camps in Cox’s Bazar, as well as in Bhasan Char island (Table 1). The quantitative sample included 834 young people living in Cox’s Bazar. It included slightly more females than males (54% versus 46%) and is split into two age cohorts, the younger larger than the older (62% versus 38%) (see Table 2). Of the young people in the quantitative sample, 66 (8%) have a functional disability even with assistive device. Of the 449 females in the sample, 194 (43%) have been married. A smaller number (131) were married prior to the age of 18. This report refers to the younger cohort (who were mostly aged 10–12 years at baseline and were a mean of 16 years old at midline) as ‘adolescents’. It refers to the older cohort (mostly aged 15–17 at baseline and a mean of 20.5 years old at midline) as ‘young adults’.

Table 1: Mixed-methods research sites

	Quantitative fieldwork sites		Qualitative fieldwork sites	
	Fieldwork sites (Cox’s Bazar camps and Bhasan Char)	No. of respondents	Fieldwork sites (Cox’s Bazar camps and Bhasan Char)	No. of respondents
Total	25	834	8	73

Table 2: Quantitative sample

Quantitative sample – Cox’s Bazar			
	Female	Male	Total
Adolescents	249	266	515
Young adults	200	119	319
Total	449	385	834



Findings from the quantitative survey were complemented by in-depth qualitative research across 7 camps² in the Ukhia and Teknaf *upazilas* (sub-districts) of Cox's Bazar, with a sub-sample of 73 Rohingya and Bangladeshi adolescents, their families and communities (see Table 3), using interactive tools with individuals and groups.³ Researchers also undertook qualitative interviews with 21 adolescents, caregivers and key informants in Bhasan Char island.

Prior to commencing research, GAGE secured approval from ethics committees at ODI and George Washington University, as well as from the Institute of Health Economics from the University of Dhaka. We also secured informed assent from adolescents aged 17 and under, and informed consent from their caregivers, and from adolescents aged 18 or above. There was also a robust protocol for referral to services, tailored to the different realities of the diverse research sites.

Table 3: Qualitative sample

Cox's Bazar			
	Female	Male	Total
Adolescents	15	13	28
Young adults	16	6	22
Parent focus group discussions	3	3	6
Young people focus group discussions	3	3	6
Key informant interviews	3	8	11
Total	40	33	73
Bhasan Char			
	Female	Male	Total
Adolescents	7	2	9
Young adults	3	1	4
Parent focus group discussions	1	1	2
Young people focus group discussions	1	1	2
Key informant interviews	2	2	4
Total	14	7	21

² We have anonymised the camp names to protect the privacy of study participants, and refer to them here as camps A–G.

³ Some qualitative quotes presented in this paper are from young people aged over 25. Following the Government of Bangladesh and UNHCR's joint registration exercise (a process begun in 2019) via the Biometric Identity Management System (BIMS), Rohingya refugees' personal identities were accurately captured via biometric data, including fingerprints and iris scans, securing each refugee's unique identity, family links and identifying information. Previous to this exercise, and during the time of the GAGE baseline data collection, many Rohingya were not able to confirm their exact age, which they were more accurately able to report on during midline data collection, hence some outlier ages.

Findings

Our findings are presented in line with the GAGE conceptual framework, focusing on: psychological distress and emotional resilience; access to peer networks and supportive adults; substance use; and access to quality psychosocial services. The findings reported in the following sections refer to mixed-methods findings from Cox's Bazar, while qualitative data from Bhasan Char is reported in Box 3.

Psychological distress and emotional resilience

The GAGE midline survey included three internationally validated instruments for measuring symptoms of psychological distress, depression and anxiety, and resilience: the General Health Questionnaire-12 (GHQ-12)⁴; the Patient Health Questionnaire-9 (PHQ-9)⁵; the Child and Youth Resilience Measure (CYRM)⁶; and the Generalised Anxiety Disorder (GAD) scale measures (Kroenke, 2001; Mäkikangas, 2006; Spitzer, 2006). Findings from the General Health Questionnaire-12 (GHQ-12) found that 22% of young people had scores indicative of emotional distress. Young adults (31%) were significantly more likely to be distressed than adolescents (17%) (see Figure 2).

The survey, using the Patient Health Questionnaire-9 (PHQ-9) instrument, also found that more than a quarter (29%) of Rohingya young people had scores indicating

mild to severe depression. Mild depression (23%) was more common than moderate-to-severe depression (6%). Although gender differences were insignificant, cohort differences were not. Young adults were more likely to be mildly depressed (27% versus 20%) and moderately-to-severely depressed (10% versus 3%) than adolescents (see Figure 3).

When using the Generalised Anxiety Disorder (GAD) scale, the midline survey found that nearly one-fifth (18%) of Rohingya young people reported feeling anxious. Mirroring the findings on depression, milder levels of anxiety were more common than moderate or severe levels (15%, 2% and 1% respectively) (see Figure 4). Again, although gender differences were insignificant, cohort differences were not. Young adults were more likely to have mild (19% versus 13%) or moderate (3% versus 1%) levels of anxiety than adolescents. Young adults and adolescents reported similar levels of severe anxiety.

The midline survey also included the Child and Youth Resilience Measure (CYRM), which measures young people's resilience and ability to overcome obstacles and their ability to negotiate the psychological, social, cultural and physical resources able to sustain their well-being (Resilience Research Centre, 2019). It asks individuals whether they agree with statements like '*I have people I want to be like*' and '*I know where to go to get help*'. Dividing the sample into high, moderate and low resilience – based on the distribution of scores within camps – young people were more likely to fall into the moderate (65%) and high

Figure 2: Proportion of young people with symptoms of emotional distress, based on the GHQ-12, by cohort

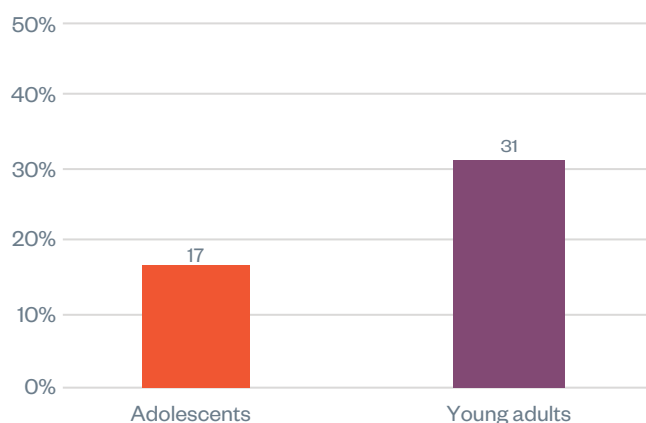
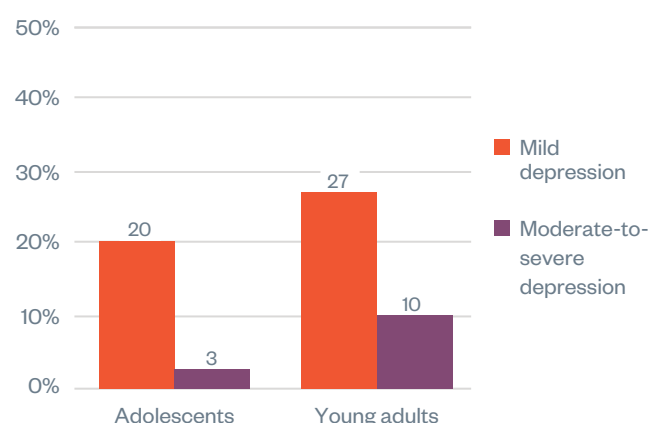


Figure 3: Proportion of young people with symptoms of depression, based on the PHQ-9, by cohort and level of depression

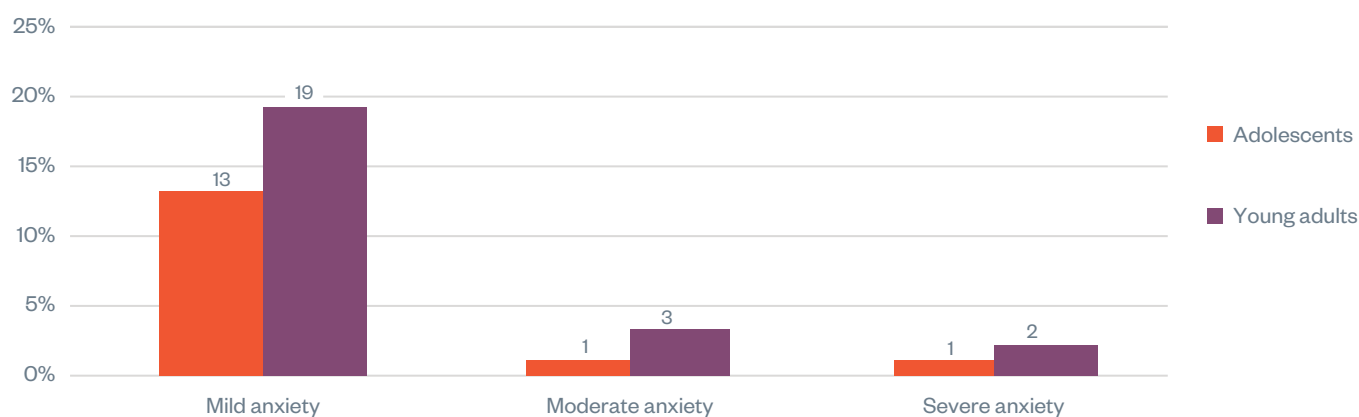


4 The GHQ-12 is an internationally validated measure of psychological distress. Scores equal to or above 3 suggest distress.

5 The PHQ-9 is an internationally validated measure of depressive symptoms. Scores between 5 and 9 indicate mild depression. Scores between 10 and 14 indicate moderate depression. Scores of 15 or above indicate severe depression.

6 Child and Youth Resilience Measure (<https://cyrm.resilienceresearch.org>).

Figure 4: Proportion of young people with symptoms of anxiety, based on the GAD, by cohort and level of anxiety

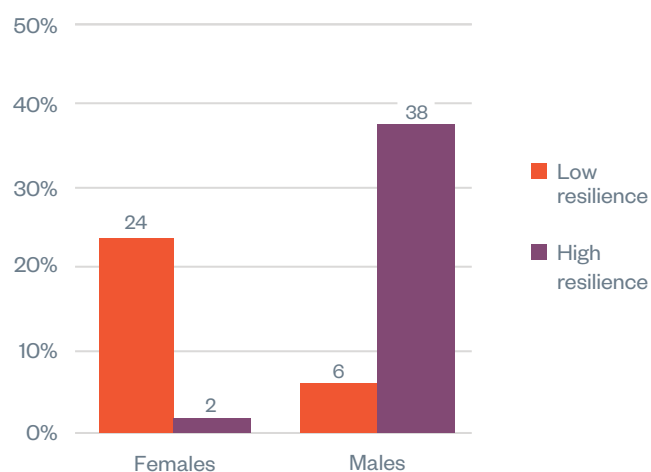


categories (19%) than the low category (16%). Critically, young people’s scores varied by gender, with females less likely than males to have high emotional resilience scores (6% versus 38%), while also being significantly more likely to have low resilience scores (24% versus 2%) (see Figure 5). Cohort differences were not significant, but young people with disabilities had lower levels of resilience (see Box 1).

In the qualitative data, there are clear gender differences with regard to the reasons for emotional distress and resilience. Rohingya girls and young women often relate their distress to the gendered restrictions they face, including limited access to education, limited mobility, and the prospect and experience of early marriage. A 14-year-old girl from camp B, for example, lamented the loss of her friendships as a result of reaching menarche (first onset of menstruation) (for additional discussion of the many limitations Rohingya adolescent girls face upon research menarche, see Guglielmi et al., 2024a; 2024b), and the negative feelings she has as a result:

I loved going outside and celebrating with children my age. But now I can’t do that anymore. When I had my first period I felt very sad. I was only thinking and asking God, ‘Why? Why did you give me this? What did I do?’. Since I have had my period, I can’t go out anymore. Yes. I used to go to Shantikhana [‘peace house’, or women- and girl-friendly space] and talk while learning to sew there. As soon as I started my period I stopped going there too. I am not allowed to go there. So I don’t learn any skills now.

Figure 5: Proportion of young people with low and high resilience scores, based on the CYRM, by gender



While many girls expressed distress and sadness upon reaching menarche due to their loss of childhood joy and liberty, some equally expressed resilience and emotional coping in the face of this transition. A 17-year-old girl from camp A explained, ‘Everyone feels upset once they have their first period. Suddenly they can’t go outside and have to remain inside their house day after day. It is exhausting at first. But I got used to it.’

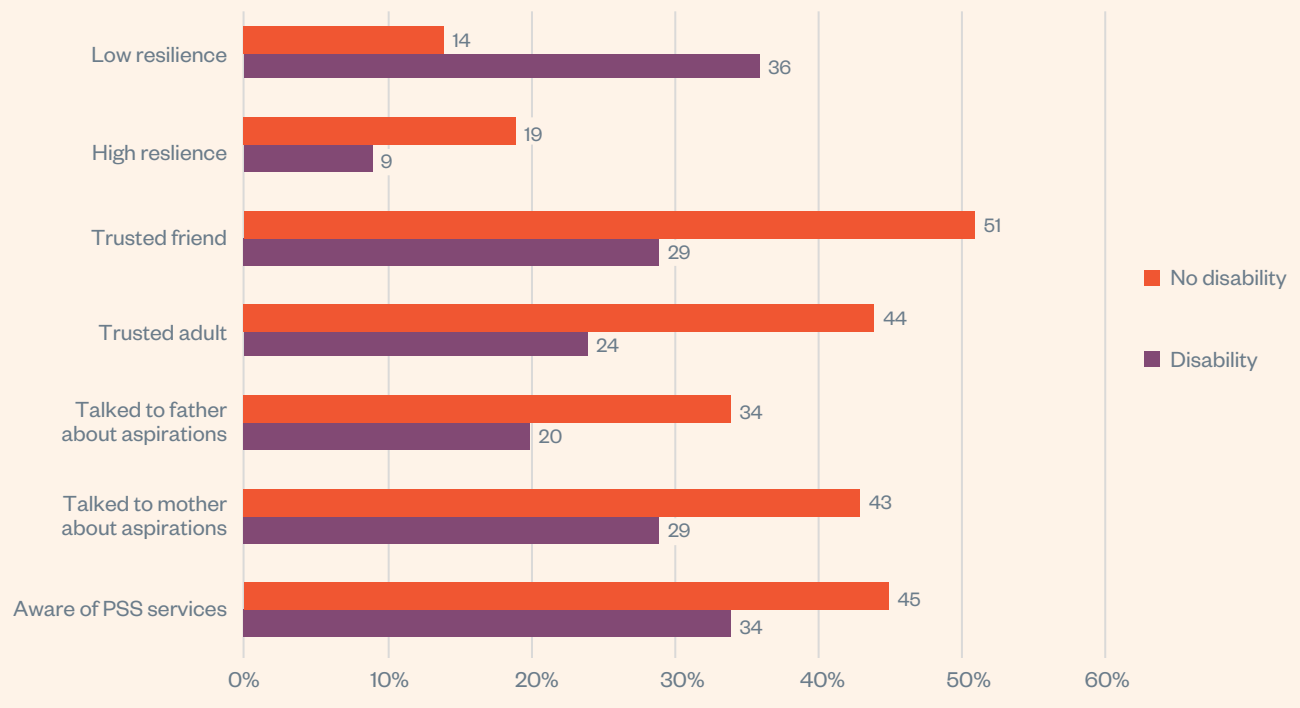
Notwithstanding the apparent sadness many adolescent girls face when required to stay at home due to stringent gender norms precluding their mobility and access to community spaces, parents see this custom as protective of their daughters – particularly a girl’s personal dignity and honour, but that of her family too – and as safeguarding the girl’s future marriage prospects. In a focus group discussion with fathers of adolescents in camp A, one participant explained that:

Girls can’t go out. A girl is like a candle, if a man lays his hand [on her] she will melt. Talk a little today, meet a little tomorrow ... it gets worse. That’s why we don’t let girls go out when they grow up [‘grow up’ means when a girl’s body and mind matures] ... If it gets bad ... it becomes difficult to get her married. So, we keep her in the house

Box 1: Psychosocial well-being of young people with disabilities

With the caveat that the quantitative sample includes only 66 young people who meet the strict definition of disability (that is, they have a functional disability even with an assistive device) midline findings suggest that disability shapes Rohingya young people’s psychosocial well-being in multiple ways. Compared with their peers without a disability, young people with disabilities are more likely to demonstrate low levels of resilience (36% versus 14%), less likely to demonstrate high levels of resilience (9% versus 19%), less likely to have either a trusted friend (29% versus 51%) or trusted adult (24% versus 44%), and less likely to have talked to their parents about their aspirations (20% versus 34%) (see Figure 6). This has translated into higher levels of distress (43.8% versus 20.4%), moderate to severe depression (15.3% versus 4.8%) and severe anxiety (6.2% versus 0.7%).

Figure 6: Psychosocial well-being indicators, by disability status



when she grows up, we don't let her go out. She is not even allowed to go to school. Although it is necessary [to go to school], what I said earlier, is what makes us afraid. We don't let them study because of fear.

Child marriage is the cause of profound despair for many Rohingya females, and some young women were very articulate when expressing their pain upon learning that they would be married off as adolescent girls. A 21-year-old young woman in camp C recounted:

When I was married off [at 16 years old] I felt like the world was breaking. I cried a lot that day ... I felt bad about his age the most [husband was 40 years old when they married]. He was such an old man and I was just an adolescent girl.

Another 20-year-old young woman from camp A recounted her suicide attempt to escape marriage: *'Because they married me off at 14 years old, I even drank Detto [concentrated antiseptic solution] [translator's note: this young woman meant that she attempted suicide by drinking Detto].*

Rohingya males also articulated worry and emotional distress, but typically spoke about their distress being related to context limitations (including their limited access to educational progression or employment), equating these to their displacement status, not their gender. A key source of anguish expressed by adolescent boys and young men was a lack of opportunity for learning, progressing in their education, and the limited prospects of decent employment. A 19-year-old young man from camp C explained that:

I could roam around freely if it was my country. But I don't have my country anymore. Also, if a boy wants to get a scholarship and pursue his studies in a foreign country, he cannot. These are the kinds of situation which disturb my peace of mind.

These views were echoed by a 22-year-old young man in camp D, who said, *'When I want to do something but I can't do it, I feel sad. I want to go to college and learn but I cannot.'* Others described how the limited employment opportunities available to them cause poverty-related anxiety and hopelessness. In a focus group discussion with males in camp C, one participant mentioned that:

There are very few opportunities to work outside the camp. If you flee and work somewhere outside the

camp, there are chances that they might not pay your salary and you can't even protest.

Although it appears that Rohingya boys equate curtailed opportunities to learn and work with their displacement status, it remains unclear whether these opportunities would have been notably improved had they stayed in Myanmar.

In addition to gender-specific experiences of emotional distress, the qualitative data also revealed pronounced anxiety among males and females alike with regard to deep fears of community violence. Violence in the community poses intense challenges to young people's mental well-being (see Box 2) and appears to be intensifying as time passes.



A 16-year-old TikTok star posts videos about travelling and poetry, Cox's Bazar, Bangladesh © Nathalie Bertrams/GAGE 2024

Box 2: Young people's anxiety and fear of community violence

Rohingya young people reported intense concern about what they described as pervasive community violence. With regard to psychosocial well-being, community violence was one of the most frequently articulated worries, though adolescents remain cautious and fearful of disclosing any identifying information of what exactly and whom they are fearful of. Security conditions across the Rohingya camps in Cox's Bazar are deteriorating, with 60% of community violence and security incidents reported since 2017 taking place over the past 12 months (April 2022 to April 2023) (Hözl, 2021; Guglielmi et al., 2022; ACAPS, 2023). At least 10 armed groups are currently active, including Rohingya armed insurgency groups, the most notorious of which is the Arakan Rohingya Salvation Army (ARSA), known as *Harakah al-Yaqin*, which operates in both Bangladesh and Myanmar (ACAPS, 2023). Insurgency groups appear to compete for power, resources and illicit trades, creating intense and widespread fear among communities – as mentioned by a 16-year-old girl in camp B: *'Actually, I feel unsafe everywhere. There's always violence and killings.'*

Experiences of community violence are also less gendered than other worries. For girls and boys, being out on the camp streets – going to paid volunteering opportunities, for instance, or travelling to and from a place of learning – presents dangers. One 15-year-old boy from camp C described his experience:

Robbers got me when I was going to my private tutoring session ... They asked me where I was from. They threatened to take me to Myanmar ... They slapped me [and] they took the money I had on me ... There's no safe place to go here, it makes me sad. I'm afraid at night.

The qualitative data included accounts of girls who were also fearful (particularly at night) of being kidnapped, killed or raped in the camps. A 17-year-old girl from camp C crystallised a common sentiment: *'There is no safe place in this camp or other camps. The condition is the same in every camp. Peace is nowhere.'* A 16-year-old girl from camp B said, *'I can't sleep at night in fear ... It wasn't like this before.'*

One key informant spoke about internal Rohingya groups perpetrating violence within the community: *'We don't know what benefit they get by killing innocent people ... they start setting fires ... They slit people's throats in daylight. I am telling you, but if it is leaked it will be on my life.'*

The deterioration in community safety has led to infrastructure destruction, killings and fire incidences, wreaking havoc and instilling fear in the Rohingya community. Between 2021 and 2022 Bangladeshi authorities reported more than 220 fire incidences in the camps, at least 60 of which were classed as sabotage and more than 60 had unknown causes (though accounts of gang retaliation have been hypothesised) (ACAPS, 2023). Many of the fires were extensive and destructive, burning dwellings, hospitals, learning centres and a variety of facilities. Worsening matters, at least 16 Rohingya community leaders and camp representatives – primarily majhis – have been murdered in 2022 and 2023, instilling widespread fear. Boys and girls in the GAGE sample expressed intense worry:

I do [feel scared in my life] that someone will abduct me or kill me ... They killed majhis. (15-year-old boy, camp B)
[The majhi] was suddenly killed at night ... They came from the hill, entered the house and left after killing. We don't know [anything else] ... In his body, one bullet and a knife mark were seen. It is normal to be afraid. They have killed one so it won't take much time to kill another. Then suddenly there were fire accidents out of nowhere. (14-year-old boy, camp B)

They steal gold, blindfold people, and slaughter people to steal things ... They set fire to houses and have burned down 200–250 houses in the camp. (29-year-old young woman, camp D)

Adolescents also mentioned that theft is on the rise. A key informant interview from the Rohingya community in camp A mentioned, *'It's calm in the day but at night we cannot sleep for fear of theft, and I have fear in my heart that someone will burn down my house.'*

Adolescents and parents alike commented that community violence has been increasing over time and that inter- and intra-community distrust is a by-product. An 18-year-old young woman from camp F mentioned *'sleeping with our doors open'* two or three years ago, whereas now, the Rohingya are terrified of violence. To counter violence – particularly at night-time when humanitarians are not allowed in the camps – community leaders have set up watchgroups, though it is unclear how successful these are in limiting community violence.

Substance abuse

The midline survey found that by early adulthood, smoking is common among males. Of young men, 24% reported smoking cigarettes, compared with 6% of adolescent boys (see Figure 7). Tobacco use was extremely rare among females.

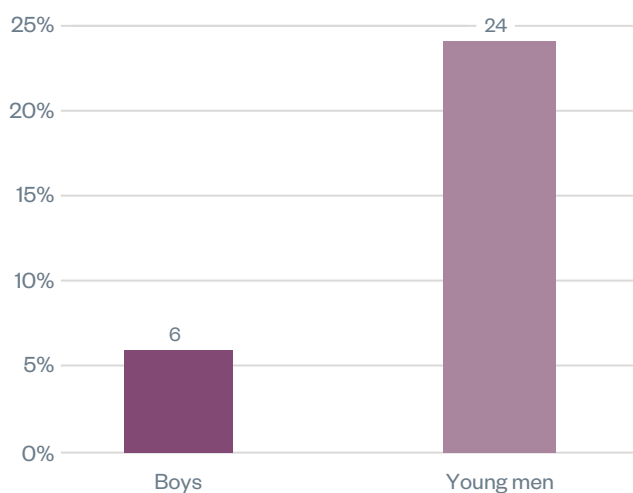
Qualitative data underlines that substance abuse is commonplace among adolescent boys (and especially young men) in the Rohingya camp context. In a focus group discussion with mothers of young people, one participant explained that, *'There are thousands and thousands of boys who smoke cigarettes and weed. They use [drugs] and also do business [selling drugs].'* This view was echoed in a focus group discussion with adolescent boys in camp A, with one participant commenting:

Those who are studying understand things, those who are not studying are bad, they roam the streets, do no work, smoke cigarettes and consume marijuana ... trade stolen Yaba tablets [a form of methamphetamine very common in South and Southeast Asia] and engage in illegal activities.

A focus group discussion with adolescent boys and young men in camp C echoed these views, with one participant adding that limited opportunity for socialising and for learning exacerbates drug use:

They [boys] consume weed and alcohol and stay high for most of the time. They try to get close with the girls, they disturb the girls, they wander around the camp and indulge themselves in wine, weed and other drugs and waste their days. The boys are getting spoiled. If the necessary skills were taught, it would have been useful.

Figure 7: Proportion of males who smoke, by cohort



Data also shows that limited availability of safe areas for leisure and socialising among peers also increases boredom and idleness, increasing the lure of drug use. A focus group discussion with boys and men in camp C mentioned, *'If there was a field [to play in] everyone would have spent their time playing and chatting with each other and would have been involved in illicit activities.'*

Married Rohingya females associated husbands' drug use with a worsening of intimate partner violence in the household. A 22-year-old young woman in camp B, for example, explained that: *'Yes, some girls say that their husbands torture them. Their husbands beat them ... they do drugs.'* Several other personal accounts confirmed this finding. Similarly, a 21-year-old young woman from camp A recounted her husband's drug use as exacerbating intimate partner violence:

I expected what happened to me. I thought it was in my destiny. After three days [of marriage – both husband and wife were 16 years old at the time], he went to jail and I came back to my mother. People said to the police that he was a drug dealer and drug addict. After he left jail, I didn't want to accept him. He had some very bad habits. He used to go to other girls and he used to take drugs. He would beat me too. If I went outside without permission ... My son was small and he wasn't having breast milk. If I wanted to get water for my son, he would say rude things to me and beat me. He was very angry and screamed at me and started beating me like a maniac. He was very abusive. He would start fighting as soon as he entered the house. As soon as he entered the house ... he used to use substance ... and start physical fighting. He always had drugs. So he always fought with me when he came home. He used whatever he earned to have drugs.

Qualitative data suggests that authorities are aware that drug use (and especially the drug trade) is occurring in the camps, yet clamping down on this appears difficult. Although young people did mention that jail can be a consequence for getting caught selling drugs, adolescents mentioned different forms of punishment for drug users. A 13-year-old girl from camp C explained:

We used to get more [food] rations, now we get less. Those who take 'Y' [Yaba] get less rations. They get rations even less than before but I don't know the reason why they get less.

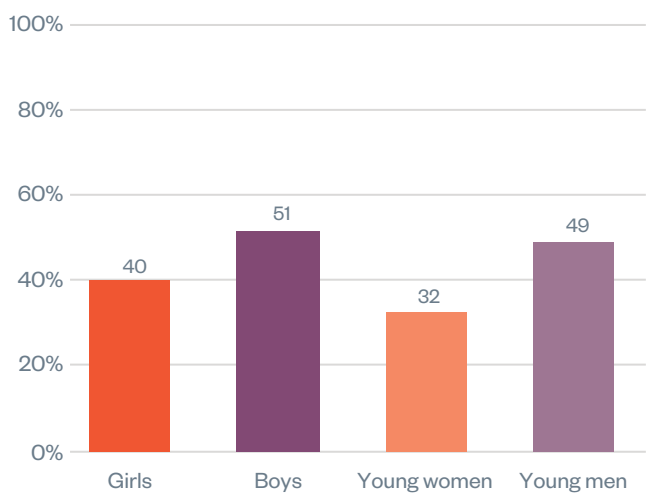
Whereas boredom and limited opportunities for personal, educational and employment-related growth all seem correlated with drug use, poverty and restricted opportunities to take up paid work seem correlated with drug trade. The extensiveness of substance abuse and sale in this context led a community volunteer key informant from camp A to say, ‘Yes, I think the main risk for adolescents is the drug business.’

Support from family and other trusted adults

At midline, less than half (43%) of Rohingya young people reported that they had a trusted adult in their lives, with both gender and age influencing responses. On the whole, females were less likely to report having a trusted adult than males, and the gender gap was larger among young adults than among adolescents. Of the latter, only 40% of girls but 51% of boys reported having a trusted adult (see Figure 8). Among young adults, only 32% of young women but 49% of young men reported the same.

The midline survey asked adolescents and young adults whether they were able to talk to their parents about a variety of topics, including education, future work, personal dreams and aspirations, and religion. Across all topics, females were less able to talk to their parents than males.⁷ Looking only at dreams and aspirations, less than half of young people (41%) reported that they could talk to their mother and only a third (33%) could talk to their father. While cohort differences were insignificant, gender

Figure 8: Proportion of young people with a trusted adult, by gender and cohort



differences were large. Girls and young women reported being less able than boys and young men to talk to either their mother (27% versus 58%) or their father (15% versus 54%) (see Figure 9).

The survey also found that girls and young women are less likely than boys and young men to be able to discuss religion with their mother and father. Of males, two-thirds (66%) reported that they could discuss religion with both their mother and their father (see Figure 10). Of females, 54% reported that they could discuss that topic with their mother – but only 26% with their father.

Finally, the survey data shows that only half (51%) of Rohingya young people have a role model outside the

Figure 9: Proportion of young people able to talk to their parents about their dreams and aspirations, by gender

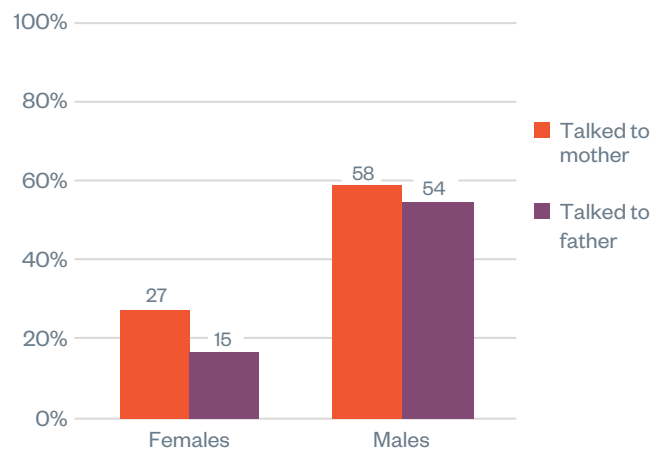
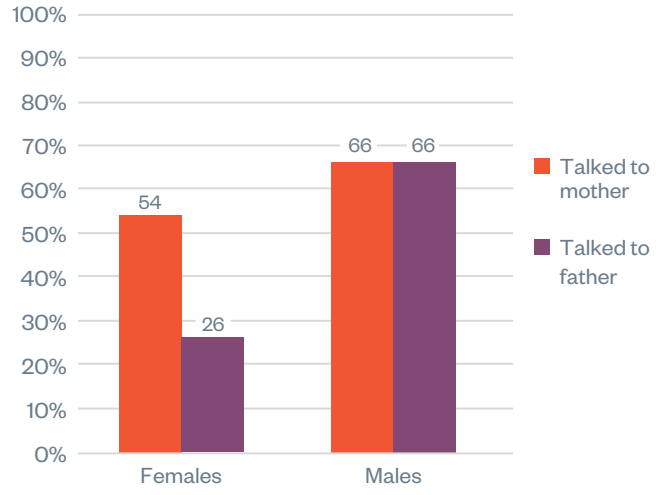


Figure 10: Proportion of young people able to talk to their parents about religion, by gender



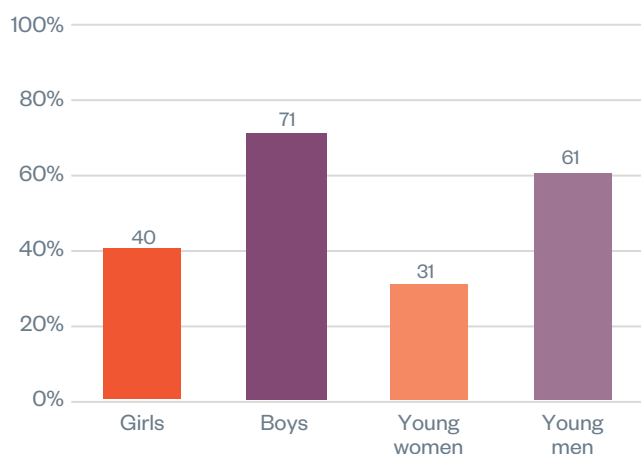
⁷ Rohingya girls and young women are extremely unlikely to attend school or to work, making conversations with their parents about education and future work unlikely.

home. There are significant cohort and gender differences. Adolescents are more likely to have a role model outside the home than young adults; and males are more likely to than females. As Figure 11 shows, 40% of girls and only 31% of young women have a role model outside the home, compared with 71% of boys and 61% of young men.

Qualitative findings help to nuance the survey findings. During qualitative interviews, most young people spoke of their parents as their most important source of psychosocial support and, in line with the survey data, nearly all young people reported being closer to their mother than their father. A 15-year-old girl from camp C noted that, *'My mother gives me advice on my mental health and I share my thoughts with her'* – a finding that resonated across age groups. A 20-year-old young woman from camp A recounted, *'My mother used to take care of me when I was pregnant. She looked after everything. My treatment cost, my clothes, my mother gave everything.'* A 13-year-old boy in camp B stated, *'My parents support me, they tell me to go to school and they give me money.'* Older young men echoed these findings. A 21-year-old young man in camp C commented that, *'My mother is my favourite person with who I share everything ... she always looks after me.'*

Young people's reliance on their mother as opposed to their father for psychosocial support and sharing is shaped by several factors. First, due to prevailing gender norms, it is mothers and not fathers who are children's primary caregivers. Most young people spend far more time with their mother than with their father – a pattern that intensifies greatly for girls upon reaching puberty, whereupon they are largely confined to the household.

Figure 11: Proportion of young people with a role model outside the home, by cohort and gender



A 14-year-old adolescent girl from camp B explained her emotional and physical proximity to her mother:

I tell my mother about anything that happens. I tell her about housework and what needs to be done. I remind her to buy things for the house and I tell her about any sickness or discomfort I feel. I only talk to her because I spend most of my time with her. I stay with her all day long. It feels good to talk to her, she is my mother. She is the most important person in my life. I respect her because it's my duty to do so.

Second, and although this was less pronounced in the qualitative data, mothers appear more lenient and emotionally aware than fathers, and thus represent a better and more accessible form of support. A 15-year-old girl from camp C explained that it was her mother who agreed for her to continue studying through private Rohingya tutors (see Guglielmi et al., 2024a, for a discussion of the educational opportunities available in this context), following a frank discussion with her daughter on this theme. She explained:

Well, I wanted to study. And my older sisters, they studied more than me and so they have jobs. They earn money. So I said it would be good if I can earn too. I said, 'If I study I can do that.' I said all this to my mother. She said, 'Okay, alright. As you wish.' So she admitted me into private study ... my mother and father pay for my education now. Some people here don't want their girls to go out as it makes them [girls] turn bad. But studying is important. It could be told to them, but they may still not want to teach them. Girls will just get married and go to their in-laws' house. What good would studying bring to her life? So that's also why parents don't let them go. But some parents understand that even if the girls can't do anything with their education, they can teach their children things.

Rohingya young people also reported being able to rely on other forms of adult support beyond their parents, especially in particular instances. For example, a 22-year-old young man from camp B explained different avenues of support depending on whether he encounters problems within the camp context or outside of it: *'Parents help if something bad happens outside the camp. And there is majhi [community leader] of our camp block if it happens inside the camp.'* Other adults in the community can also provide young people with support and opportunities to be listened to, and when this happens, it helps to build young

people’s confidence and self-esteem. A 16-year-old girl from camp B who volunteers in a learning centre explained:

The authorities listen to me, it feels great. I can ask for anything from school ... Suppose we need notebooks at school – if I tell them that, they will send more books. They listen to me. They listen to what I have to say and so I listen to them too.

Support from peers

Half of our sample reported having a trusted friend at midline, with significant gender and cohort differences. Overall, Rohingya males were more likely to report having a trusted friend compared to females, and adolescents were more likely to report having a trusted friend compared to young adults. Adolescent boys (73%) are the most likely to have a trusted friend; young women are least likely to (25%) (see Figure 12).

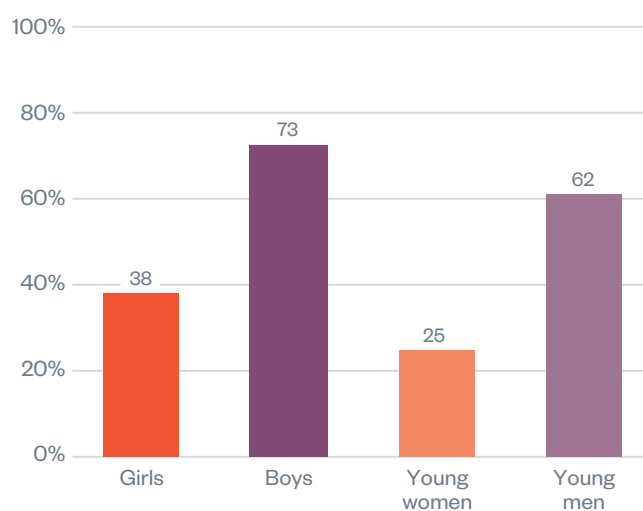
The benefits of friendship were mentioned across genders and age cohorts in the qualitative data. Whereas many parents provide advice with problems and generalised forms of support, friends offer young people respite, distraction, laughter and fun, as well as emotional support. An 18-year-old young man from camp C mentioned, *‘I am outside most of the time. I spend most of my time with my friends and I am happy with them. We cannot sit all day at home. When I go out with my friends, I am happy.’* A 17-year-old young woman from camp A said, *‘Among all the people I talk to, I like my friends who are my age most. When we sit together and talk, then I feel good.’* This sentiment was echoed by a 21-year-old young woman from camp E, *‘If we talk to our friends and people around our age and laugh together, we feel good. We feel*

peace.’ And a 15-year-old from camp C, *‘If I feel bad about something I tell her. If she feels bad about something, she tells me ... We can share anything ... with each other ... If she likes any of my clothes I let her borrow them. And if I like any of her jewellery items she lets me have them.’* Young people also mentioned sharing their dreams and aspirations for the future with their friends.

Males especially mentioned appreciating friends based on their moral character, and for being exemplars in the community and upholders of ethical code and custom. A 14-year-old boy from camp B said, *‘I like that he is studying with me. He always tells me about good and bad and always tells me whom I should I talk with and whom I should not.’* This finding was echoed by another 14-year-old boy from the same camp, *‘I like that he [friend] is studying and that he says his prayers.’*

In line with the survey findings, young people are less likely to benefit from having a trusted friend as they age and transition to young adulthood. This has to do with curtailed opportunities to venture beyond their household and engage with the wider community, including friends. In fact, qualitative data shows that spaces for learning – through learning centres, private tuition, religious educational provision – are conduits to friendships, and provide opportunities for like-aged young people to meet and spend time together. Whenever educational opportunities are interrupted, friendships appear to dissipate. A 16-year-old girl from camp B explained, *‘I can’t go to my friends when I feel troubled. I have to stay at home.’* Transitions to young adulthood also correspond to changes in familial responsibilities which can prevent some young people from sustaining their friendships. An 18-year-old young man from camp C mentioned that, *‘I was unmarried before. I did not go to work. I could spend all of my time with my friends. Now I cannot do that.’* A 22-year-old young man from camp D similarly commented, *‘We spend less time together than before, because he goes to teach private lessons and I also teach private lessons to boys and girls.’*

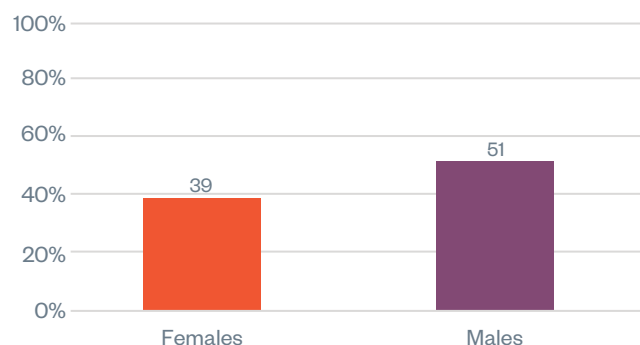
Figure 12: Proportion of young people with a trusted friend, by cohort and gender



Access to psychosocial services

At midline, survey findings indicate that less than half (44%) of Rohingya young people are aware of where and how to access psychosocial support services. While there were no significant age differences, suggesting that adolescents and young adults are equally aware of these services, there were large gender differences (see Figure 13). Males are significantly more likely than females to report knowing where and how to access services (51% versus 39%).

Figure 13: Proportion of young people reporting awareness of where and how to access psychosocial support services, by gender



However, knowing where and how to access psychosocial support services does not translate into service uptake. Survey data showed that only 7% of young people have accessed services for themselves, with females significantly less likely to have accessed services (5%) compared with males (10%) (see Figure 14). The survey also found that 10% of young people would be interested in accessing services, with no differences by gender or age cohort.

Qualitative data confirms mixed knowledge among our sample about mental health and psychosocial well-being services available in the camps, and in turn uptake of those services. A 15-year-old boy from camp B stated:

No, there are no services or meetings held for the mental well-being of boys and girls where they are taught what to do during stress, and what would make them feel better, I have never heard of these or heard of friends going to these meetings.

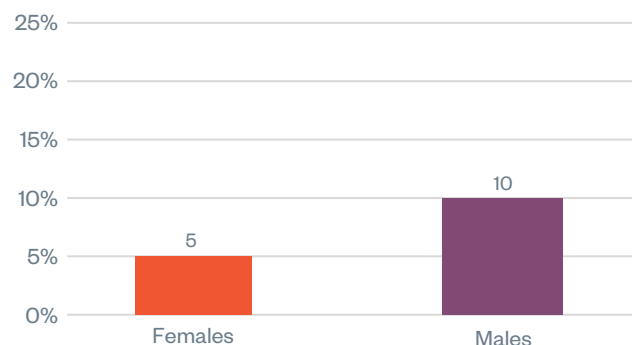
Yet a 14-year-old boy from the same camp gave a very different account:

NGOs support us the most [with regards to healing the restlessness of our mind]. Do I feel good when our house burns? I will feel bad! ActionAid staged a drama like this. I participated in that. Staff took some sessions about many topics. We played dramas on how someone can calm himself from suffering when their house is burned. It went well. When something like this happens, I will explain to my mind by saying that this has happened from the side of Allah, this understanding is coming.

Many Rohingya females have heard about the benefits of attending the *Shantikhana*, as a 14-year-old girl in camp B commented:

They talk there. There are meetings for younger girls and older girls and there are meetings for married

Figure 14: Proportion of young people who have ever accessed psychosocial support services, by gender



women too. They teach about periods to older girls, but children can go there too, they play and play.

This comment was echoed by a 20-year-old young woman in camp A:

I talked to the sister who came and she told me to go to Shantikhana. I went and they would console me and try to bring peace to me. They would tell me it is alright and things like that. There was a girl, a sister like you, she would give me peace ... listen to me.

Benefits notwithstanding, girls are not always able to attend female-friendly spaces, or multi-purpose centres where sessions, meetings, trainings and opportunities for respite are offered. This is due to gender norms that preclude their mobility, the perceived lack of proximity to centres, or because they are perceived to cater to other age groups that are either too young (children) or too old (married women). It is worth noting that while Rohingya respondents may not consider attending these formal NGO-led sessions, there are also door-to-door community outreach activities that Rohingya females may also benefit from. In a focus group discussion with fathers in camp C, one participant explained that:

Changes are happening. In some houses, girls are not satisfied with their needs. That's why we see them depressed. They used to not tell anyone. But after going to Mukti [NGO] office [for activities and sessions], they now talk to people nicely when people come to their door. They sit outside if someone comes. They used to not come when they are called. After learning there, then they can talk to people.

In Box 3, we present qualitative findings on psychosocial outcomes for young people in Bhasan Char.

Box 3: Psychosocial well-being in Bhasan Char

Qualitative data gathered in Bhasan Char island reveals many similar patterns regarding young people's psychosocial well-being outcomes to those in Cox's Bazar, but also some notable differences that are worth highlighting. The importance of friendships was as pronounced as in the data from Cox's Bazar, with boys having more opportunity to enjoy the respite and fun provided by friendships, due to their opportunity to go to school and be with friends, as well as engage in a variety of community activities – even simply walking or sitting around together. A 17-year-old boy commented:

When I go to school I spend time with them [friends] and when I come back and sit at my shop they come. We talk about many things. We talk about sports, we talk about matches we will play here today or we will play this or that.

With regards to respondents' levels of anxiety, distress and worry, the data from Bhasan Char is mixed. Critically, qualitative data revealed that anxiety about insurgency groups and worries about community violence were significantly less pronounced compared with findings from respondents in Cox's Bazar. One 17-year-old boy mentioned, 'After coming to Bhasan Char, we can live here well. We have been benefited by coming ... I used to not go to school before [in the Cox's Bazar camps] because of al-Yaqin.' This view was echoed by a 21-year-old young woman, who said, 'That's why we moved here. Now we live without being afraid and also can sleep peacefully at night.'

This notwithstanding, worries and fears about poverty appeared more pronounced, and the limited humanitarian presence on the island (probably as a result of the newly constructed camp and the necessary time to scale up humanitarian coordination) meant that respondents felt their needs were left unaddressed. In a focus group discussion with fathers, one participant crystallised these sentiments:

We feel like we are in jail. It seems like our family is trapped in jail due to poverty. We are leading a very difficult life. There is no NGO coming here to address our problems ... You have come, and we can tell you about our problems. We can't tell anyone else. We don't know who will understand our sorrow. The vegetables we grow in the garden are sold at a very low price. And because the soil here is saline, no other plants grow; they die ... Even the pesticide is expensive. The soil in Kutupalong [Cox's Bazar] was not saline. It was easier. We didn't come here to be displaced. We want to work and earn. When we were in Kutupalong, members of one cluster [camp] could not work in another cluster. But here, members of one block are doing the work of another block and taking the money. This is our main problem. That's why we are very restless and our life is in turmoil. What else can we do other than jump into the river [commit suicide]?

These findings resonated during focus groups with mothers, who also claimed that there are no humanitarian organisations reaching out to adolescents: 'You've come for the first ever time and made a meet up with them.' As with the data from Cox's Bazar, some adolescents did know about the existence of women-friendly spaces and multi-purpose centres on the island, yet in any case were precluded from attending due to gender norms limiting girls' mobility. A 17-year-old girl commented, 'Yes, I have heard of the Shantikhana but I never go there. My husband doesn't let me go.'



Conclusions and implications for policy and programming

Overall, the GAGE midline research found that despite humanitarian coordination aimed at offering multi-sectoral and integrated mental health and psychosocial support programming, Rohingya young people display symptoms of distress, depression and anxiety. We also highlight, as hypothesised in previous literature (Guglielmi et al., 2020c), that rates of psychological distress may be under-reported in this population due to the normalisation of disadvantage and distress, and due to limited consideration of mental well-being and ill-being, beyond very extreme forms.

Our data illuminates that young people are distressed by poverty, violence (and fear of it), and limited opportunity for learning and earning. The large majority of young people, female and male, are not enrolled in learning (Guglielmi et al., 2024a) and are thus distressed for their future progression, and cut off from the socialising element of learning – girls especially. Gender norms that lead to restrictions on the physical mobility of girls translate to them being unable to access the humanitarian-led opportunities to increase their psychosocial well-being by engaging in group sessions. Finally, community violence appears pervasive – particularly at night – and remains shrouded in secrecy, due to intense fears and anxiety for retaliation should any information be leaked.

If the Government of Bangladesh and humanitarian partners want to address the multitude of contextual, societal and individual challenges affecting the mental health of Rohingya young people, they must first understand their mental health needs. GAGE mixed-methods midline research findings suggest the following key priorities for policy and programming:

- **Consider extending the use of female chaperones within camps who can escort girls to integrated centres offering mental health and psychosocial support services.** This could ensure that adolescent girls with limited mobility and young women whose husbands do not want them to venture beyond their homes will have a greater chance of participating in humanitarian-led sessions and socialising with their peers and community members.
- **Expand parenting education courses for mothers and fathers of young people.** Courses should include techniques for fostering open parent–child communication, and ways that parents can support their children to become emotionally resilient. Such courses should also address gender norms and how they impact girls’ and boys’ broader well-being by shaping both the opportunities available to them and the risks they face. Special efforts should be made to engage parents on the importance of socialisation for daughters, the multitude of risks girls face as a result of child marriage, and the prevention of intimate partner violence (for themselves and their children).
- **Seek to identify and better understand the triggers of community violence and provide risk mitigation measures to increase security in the camps, particularly at night.** Advocate with the Government of Bangladesh to increase surveillance in the camps due to widespread and escalating fear of insurgent groups internal to the Rohingya community. The security forces working in the camps should also receive training on the cultural sensitivities of the Rohingya people to better understand their crises.
- **Continue to raise public awareness of the importance of mental health,** psychosocial support networks and avenues for healthy socialisation. Door-to-door, centre-based and media campaigns should align with culturally relevant language and content, educating people about positive mental health and how to promote it.
- **Increase young people’s access to camp volunteer opportunities (in Cox’s Bazar and Bhasan Char) with stipends, and implement related skills-building programmes so that adolescent boys and girls and young men and women are able to engage in longer-term paid work in the camp ecosystem.** Our research points to poverty-linked stressors and related increase in drug use and drug trade, which is correlated with limited opportunity to engage in long-term paid work.

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About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a decade-long (2016-2026) longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org for more information.

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Front cover: A 12-year-old girl sells vegetables in Cox's Bazar, Bangladesh
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