NEEDS ASSESSMENT REPORT

Mental Health and Psychosocial Support

JUNE 2021

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ABBREVIATIONS AND ACRONYMS

CiC	Camp in Charge
FDMN	Forcibly Displaced Myanmar National
FGD	Focus Group Discussions
GoB	Government of Bangladesh
IASC	Inter-agency standing committee
IOM	International Organization for Migration
MHPSS	Mental Health and Psychosocial Support
NGO	Non-governmental organization
NPM	Needs and Population Monitoring
PTSD	Post Traumatic Stress Disorder
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
WFS	Women Friendly Space
WHO	World Health Organization
4W	Who, Where, When, What

EXECUTIVE SUMMARY

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A comprehensive Mental Health and Psychosocial Support (MHPSS) needs assessment was undertaken in Cox's Bazar between December 2020 and February 2021 to explore:

- Main stressors impacting the psychosocial well-being of host and refugee communities
- Identify the main psychological reactions related to the specific humanitarian context
- Identify existing protective and resilient factors (at individual, family and community level)
- Gain an in-depth understanding of what the communities perceive as needed services for the improvement of their mental well-being.

A total of 1,590 individuals from the host (507) and refugee (1083) communities in Cox's Bazar area participated as respondents to a questionnaire or as participants to focus group discussions.

The key stressors that contribute to MHPSS difficulties, identified by the beneficiaries were the lack of livelihoods (62.9%), basic needs and living conditions (48.38%), safety and protection (46.77%), education (41.93%), poor health conditions (22.58%), lack of freedom of movement (12.09%), and displacement due to the refugee influx (12.09%) for the host community.

For the Rohingya refugee participants, the main identified stressors were basic needs and living conditions (62.72%), education (43.19%), safety and protection (23.66%), uncertainty (23.07%), livelihoods (18.93%), poor

health conditions (18.34%), displacement (18.34%), sense of loss (13.01%), lack of freedom of movement (11.83%), previous life-threatening experiences (11.24%), national identity crisis or statelessness (11.24%).

The results demonstrate that both communities experience psychosocial difficulties with some similarities and differences between the two. The five main MHPSS difficulties experienced for more than half of the days within two weeks prior to the questionnaire by the participants of the host community are related to depression and anxiety, such as "feeling tired or having little energy" (39.33%), "little interest or pleasure in doing things" (38.68%), "feeling tension or nervousness" (37.30%), "feeling bad about myself – or that I am a failure or have let myself or my family down" (30.78%), and "feeling down, depressed or hopeless" (26.96%). The five main MHPSS difficulties experienced for more than half of the days within the last 14 days prior to the questionnaire by the participants of the Rohingya community are "feeling tension or nervousness" (37.86%), "feeling tired or having little energy" (34.58%), "little interest or pleasure in doing things" (31.51%), "feeling down, depressed or hopeless" (29.65%), "feeling afraid as if something awful might happen" (27.68%). Men from both communities were more likely to report more frequently having MHPSS difficulties for at least eight in fourteen days for some symptoms, such as "having little interest or pleasure" and "Feeling bad about myself - or that I am a failure or have let myself or my family down". Additionally, the assessment revealed important information regarding coping mechanisms, resilience factors and support systems, as the primary source of support for both groups is family, followed by religious and community leaders, neighbours, traditional healers and other respectable figures of the community.

Engaging with religious activities and discussing with friends and family are the main coping mechanisms for both samples. Moreover, most of the participants reported that they tend to continue their life quickly after hard times but have a hard time making it through stressful events.

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CONTEXT AND BACKGROUND

As of May 2021, approximately 727,219 Rohingya arrivals have been recorded since 2017, making it a total of 877,710 Rohingya present in Cox's Bazar and 1.3 million people in need of support[1]. The mass displacement of Rohingya refugees who fled Myanmar in search of safety added a burden to an already restrictive and resource-limited setting. UN agencies and humanitarian actors, alongside the Government of Bangladesh (GoB), provide services to the refugee and host populations in the Cox's Bazar area. Since the beginning of the Rohingya influx in 2017, disparities in the provision of services between the two communities exacerbated the significant challenges faced by displaced persons and host communities and the need for adequate services targeting the two populations.

Furthermore, Covid-19 has intensified the suffering worldwide and led to significant health and socio-economic consequences, impacting the psychosocial well-being of affected communities. Since the onset of the pandemic, refugees and communities residing in low and middle-income countries (LMIC), like Bangladesh, have been disproportionately impacted due to the disruption of many services and the increase of vulnerability. The Covid-19 situation underlined the importance of the mental well-being on the overall health and the prioritization of MHPSS services became more imperative than before.

Following recommendations that resulted from a rapid needs assessment that was completed in May 2020, the International Organization for Migration (IOM) conducted a comprehensive MHPSS assessment between January and February 2021 in Cox's Bazar. The assessment targeted the refugee and host communities in Ukhiya and Teknaf Upazilas (total of 1,359 respondents to the quantitative research / questionnaire and 231 participants to the Focus Group Discussions (FGD), total number: **1,590** participants from the refugee (68.11%, n=1083) and host communities (31.89%, n=507). Additionally, IOM conducted an assessment of available resources through a 4Ws[2] exercise to produce get an overview of available MHPSS services in the Cox's Bazar area. IOM always prioritizes participatory methods, including participatory assessments to guide MHPSS programmes, by involving the communities in a meaningful way and ensuring that the programmes address the real needs of the communities, in a culturally appropriate way. Apart from identifying the needs, the involvement of the community gives rich information on the existing resources and capacities.

The IOM MHPSS programme in Cox's Bazar has been implemented since 2017 and focuses on community-based activities as well as the integration of MHPSS into the primary healthcare system. The activities are addressed to both Rohingya and host Bangladeshi communities. Based on a holistic approach, the activities cover all the IASC layers, with a focus on community-based activities, as "it is proposed that refugees' response to adversity is not limited to being traumatized but includes resilience and Adversity-Activated Development (AAD)", (R. Papadopoulos, 2007).

[1] IOM Bangladesh, *Monthly Situation Report: Rohingya Humanitarian Crisis Response*, May 2021.

[2] 4Ws mapping tool: "Who is Where, When and doing What"

DESK REVIEW

Meaningful participation of communities is fundamental in all the steps of engagement of IOM in the provision of mental health and psychosocial support to both the host and refugee communities of Cox's Bazar. Communities are mobilized to share the challenges impacting their mental well-being and culturally attuned ways of support. The IOM MHPSS team is in a constant dialogue with the host and refugee communities to ensure that the design and implementation of MHPSS services correspond to their needs, mobilize their resiliency and protect their dignity.

Conflicts and insecure environments provoke disruption of the social fabric, gaps in essential services and result of distressful events, such as losing loved ones and experiencing human rights violations, impacting the lives of those who are affected. Most of the affected people will experience distress (e.g. feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability or anger and/or aches and pains, (WHO, 2019).

According to several surveys and needs assessments, the mass arrival of the Rohingya, searching for protection and hoping for better basic living conditions in Bangladesh, has had significant impact on their mental health and psychosocial well-being as well as for the host communities in most of Cox's Bazaar district. Prior to this needs assessment, IOM conducted two rapid needs assessments in 2018 and 2020.

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According to the findings of the assessment in 2018 (4th January-12th February 2018) that took place in three camp sites in Cox's Bazar with 325 participants (229 Rohingya refugees, 40 key community leaders, and 56 health workers), the main identified stressors were the lack of basic needs/social amenities of life (58%), loss of family member (51%), previous life-threatening experience (40%), national identity crisis (40%), poor health

condition (36%), lack of freedom to move outside the camp area (30%) and safety and protection issues (18%). A total of 47 per cent of the respondents reported to "be always sad", 29 per cent to "feel tense always", 27 per cent of participants manifested "grief always for their lost family members and their previous life" and 45 per cent of the total participants reported experiencing distress and other negative feelings. Children and youth participants of the assessment reported that the situation at the time of the assessment was making them feel anxious and unable to concentrate enough at school (38%) and 21 per cent were experiencing uncertainty for the future. Food shortage, lack of educational and employment opportunities, a sense of being held in captivity in the camps, and not knowing what happened to their relatives who were left behind in Myanmar, were among the main stressors contributing to their emotional distress.

Similar concerns were found in the second rapid needs assessment conducted by IOM in May 2020 with a sample of both host and refugee communities (1,337 participants, 793 from the refugee and 544 from the host community). Approximately 39 per cent of the participants reported experiencing stress, 30 per cent anxiety and 11 per cent depression-related conditions. The main indicated symptoms were changes in sleep behaviour (31%), change in appetite (23%), and somatic complaints (19%). The main identified factors influencing mental health were lack of purpose, discontent and apprehension, anxiety associated with repatriation and citizenship, food shortage, inadequate shelter, poor lighting, WASH facilities and insufficient clothing, lack of economic opportunities, and boredom.

Handicap International (now known as *Humanity and Inclusion*) conducted an MHPSS field needs assessment in 2019 with the participation of 300 Rohingya refugees. According to the findings, the three prioritized stressors for men were inadequate food, lack of employment and poor condition of the shelter. Women participants added the lack of clothes and hygiene products to the three previously mentioned stressors. Among the key findings was that 21 per cent reported feeling so afraid that nothing could calm them down in the last two weeks, followed by hopelessness to the point of not wanting to carry on living (14%), and a state of feeling upset to the point that nothing could calm them down (14%). Additionally, 36 per cent of the sample screened positive for exhibiting symptoms of mental distress and functional impairment. Being older, living with a disability, lack of community participation and lack of work were identified factors that aggravate the vulnerability of Rohingya refugees in terms of mental health.

Fortify Rights published the research "*The torture in my mind*" *The right to Mental Health for Rohingya Survivors of Genocide in Myanmar and Bangladesh* in December 2020, providing findings that shed additional light on the situation among Rohingya refugees in Bangladesh. The research took place between March 2018 and November 2020 and was conducted by a team of ten Rohingya researchers under the technical supervision of *Fortify Rights*. The analysis included information collected by 495 household surveys, 13 pre-survey focus group discussions, 33 participant feedback sessions, and 16 community workshops with Rohingya refugees. The assessment provides insight into stressors that adversely affect the mental health of the Rohingya community and the prevalence of symptoms indicative of depression, emotional distress and PTSD. Notably, human rights violations and infringement of basic human rights experienced in Myanmar, such as lack of freedom of movement and denial of access to healthcare services, restrictions on education, and violation of religious expression were found to contribute gravely to the trauma experienced by the participants. Around "*98.6 per*

cent of the survey participants reported exposure to frequent gunfire, 97.8 per cent witnessed the destruction or burning of villages, 91.8 per cent witnessed dead bodies, and 90.4 per cent witnessed physical violence against others" (Fortify Rights, 2020). Additionally, 55.5 per cent reported experiencing torture while 34.3 per cent of men and 31.1 per cent of women participants reported experiencing sexual abuse, sexual humiliation, or sexual exploitation. Regarding identified stressors they experience in Bangladesh, the main ones were limited freedom of movement (65.5%), inadequate living space (61.6%), poor physical health due to illness, injury, or disability (62%), and limited access to potable water (60.4%).

The findings of the research are indicative of the situation among the Rohingya community in terms of mental health: A total of 88.7 per cent reported experiencing symptoms suggestive of depression (e.g., "worrying too much about things", "feeling sad", "loss of interest in things you previously enjoyed doing"), 84 per cent reported symptoms suggestive of emotional distress (e.g. "feeling fearful", "experiencing bodily pain from distress / tension"), and 61.2 per cent reported symptoms suggestive of PTSD (e.g. "experiencing recurrent thoughts or memories of the most hurtful or terrifying events", "feeling as though the event is happening again", "experiencing recurrent nightmares"). Additionally, 91.3 per cent of the participants indicated facing difficulty carrying out their daily activities, such as participating in social or religious activities and maintaining hygiene. Another poignant finding is that 68.9 per cent of the participants reported feeling "humiliated or subhuman". The tools used for this research were the *Harvard Trauma Questionnaire* and the *Hopkins Symptom Checklist-25*. The participants had to reply to a series of questions related to depression, trauma and emotional distress, using a Likert scale from "Not at all" to "Extremely". According to these two tools, those with an overall average severity score above the predefined thresholds, were indicative of depression, emotional distress and PTSD.

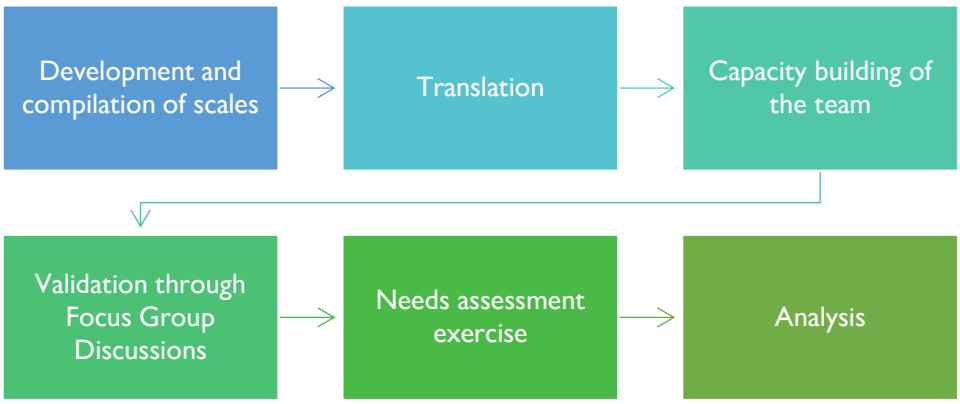
Lastly, the latest "*Joint Multi-sector Needs Assessment (J-MSNA): Refugee and host communities*" (2020) explored the impact of Covid-19 on several sectors, including Health and Protection and has given a plethora of information about the challenges the two communities face. Around 836 households of the refugee community and 911 households of the host community were assessed. Among the main concerns of the refugee community were food shortage, hygiene and sanitation-related challenges (such as insufficient sanitation facilities), denial of healthcare provision and lack of health staff on the ground, and an increase in child protection issues (child labour, children going missing, underage marriage, psychosocial distress and violence against children). Host community respondents reported food shortage and decreased income, insufficiently staffed health centres due to lockdown measures, and an increase in child protection issues, such as child labour and child marriage.

METHODOLOGY

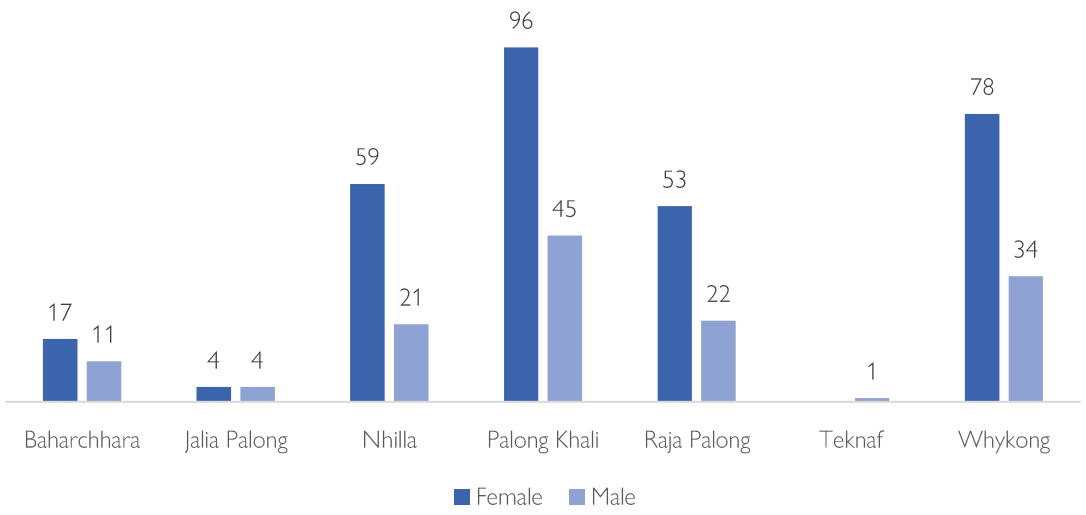
The assessment was conducted with both the refugee and host communities in Ukhiya and Teknaf Upazila and the sample of respondents was randomly selected with the support of NPM (Needs Population Monitoring unit, IOM) across the two areas. A mixed methodology was used with quantitative and qualitative parts consisting of desk review, individual assessment tools and Focus Group Discussions (FDGs). The design and validation of the selected tools took place between November and December 2020 and the data collection was performed between January 2021 and February 2021.

Sampling methodology:

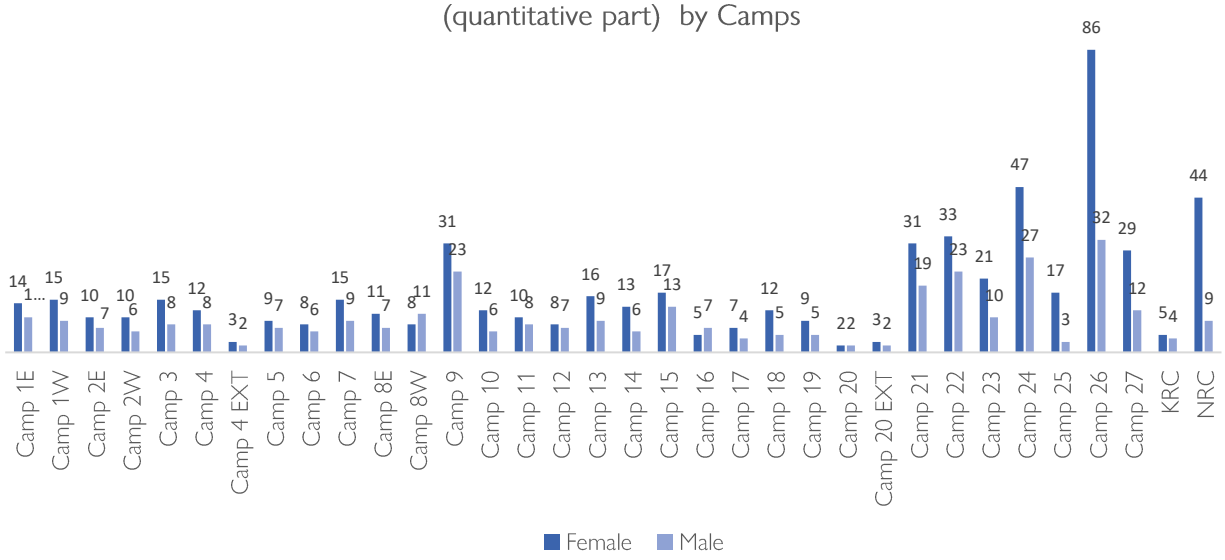
For the quantitative part (individual questionnaire) a total of 1,359 participants (refugees: n=914 / 67,3% and host: n=445 / 32,7%) were finally reached. The sample population of the FDGs consisted of 231 participants (different from the 1,359 mentioned above), coming from the refugee and host communities (refugees: n=169 / 73.2% and host: n=62 / 26.8%). The participants of the first part of the assessment were randomly selected, based on a plan prepared by NPM, aiming to have a representative sample of both communities. For this reason, the teams were guided by GPS with random pre-selected locations for all the refugee camps and host areas across the two Upazilas. Finally, 914 households were reached, targeting random households in all the 34 refugee camps of Cox's Bazar. Regarding the host community, the goal was to reach 420 households, finally reaching 445 households.



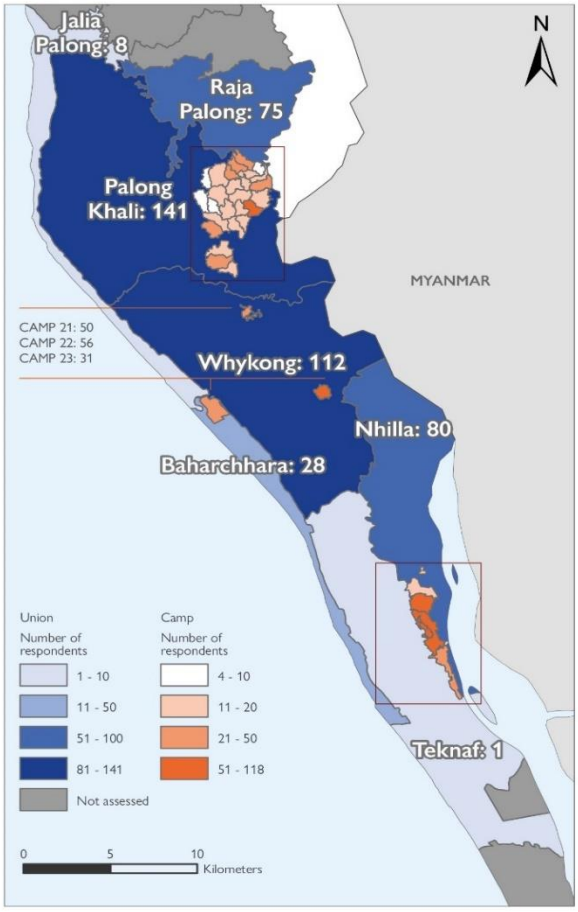
Host Community: Number of respondents to the questionnaire (quantitative part) by Union

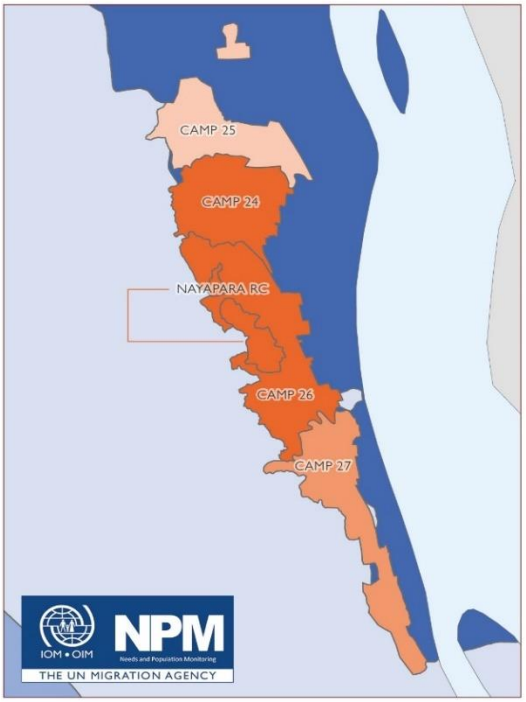


Rohingya Refugees: Number of respondents to the questionnaire (quantitative part) by Camps



COVERAGE MAP:
Number of respodents to the MHPSS assessment, by camp and union





Number of respondents per camp

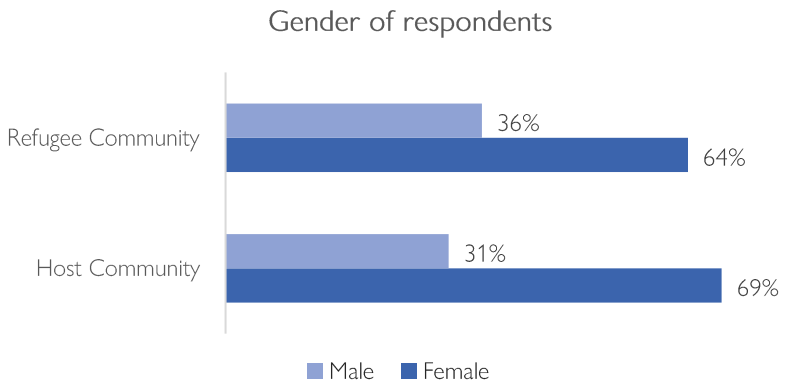
Camp	Number of respondents	Camp	Number of respondents
Camp 01E	24	Camp 14	19
Camp 01W	24	Camp 15	30
Camp 02E	17	Camp 16	12
Camp 02W	16	Camp 17	11
Camp 03	23	Camp 18	17
Camp 04	20	Camp 19	14
Camp 04 Ext	5	Camp 20	4
Camp 05	16	Camp 20 Ext	5
Camp 06	14	Camp 21	50
Camp 07	24	Camp 22	56
Camp 08E	18	Camp 23	31
Camp 08W	19	Camp 24	74
Camp 09	54	Camp 25	20
Camp 10	18	Camp 26	118
Camp 11	18	Camp 27	41
Camp 12	15	Kutupalong RC	9
Camp 13	25	Nayapara RC	53

The FGDs took place in the areas where the IOM MHPSS teams operate, targeting people of concern who live there, but are not necessarily IOM beneficiaries.

Demographic information of respondents - Adults (questionnaire)

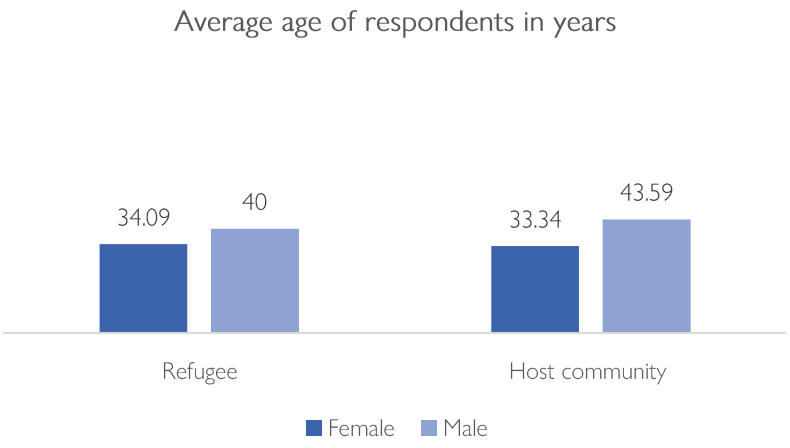
A total of 1,359 respondents participated in the quantitative part of the assessment, with 65.86 per cent female and 34.14 per cent male. Women constituted the majority of respondents for both groups (64% of the refugee community and 69% of the host community).

1,359 households	914 refugees (588 women and 326 men)	445 host (307 women and 138 men) from ukhiya and teknaf upazila



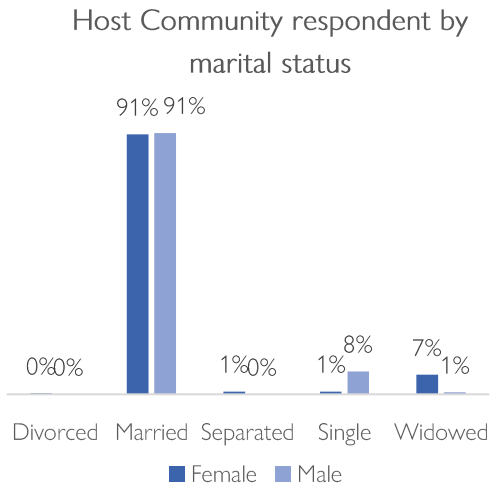
Age:

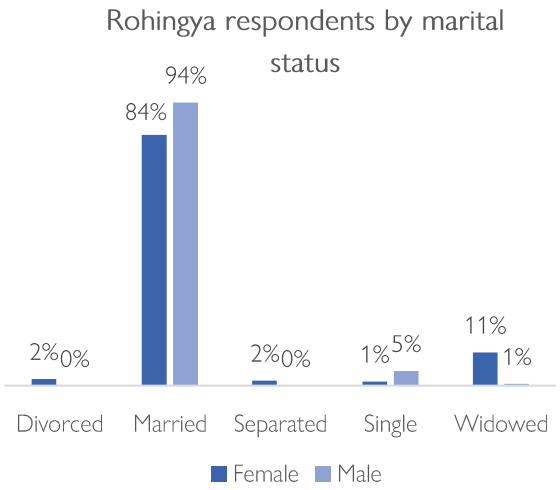
The average age of the host community respondents was 36.52 (33.34 years old for female and 43.59 years for male) and 36.20 years old for the refugee community (34.09 years old for female and 40 years old for male respondents).



Marital status:

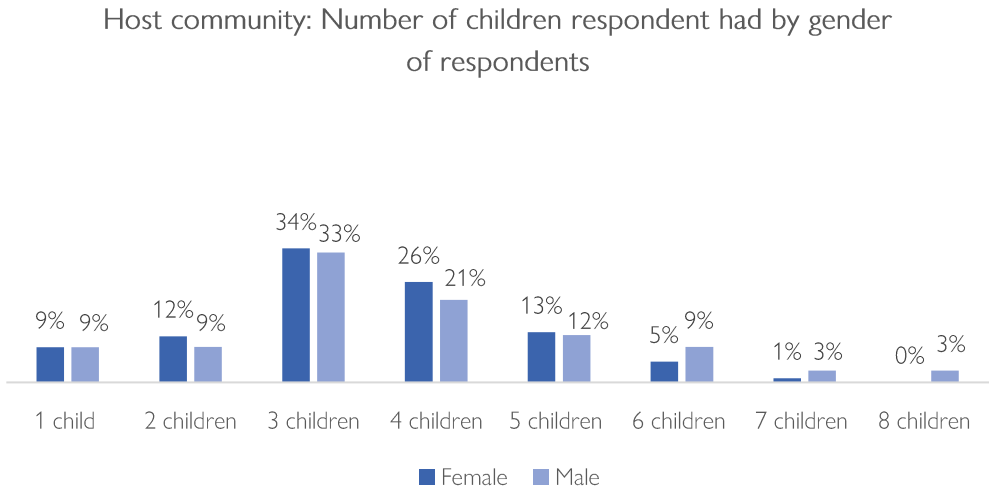
The majority of all the participants were married (91.01% of the host community and 87.53% of Rohingya refugees).





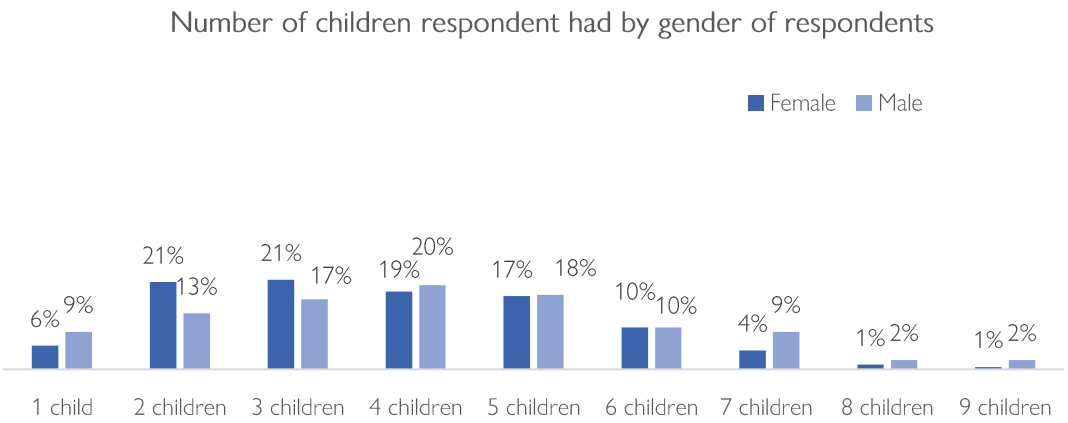
Number of children:

Host community: The average number of children was 3.50 for the host community and 3.90 for Rohingya refugees. The majority of host respondents had three children (34.13%), followed by those who had four (24.60%).



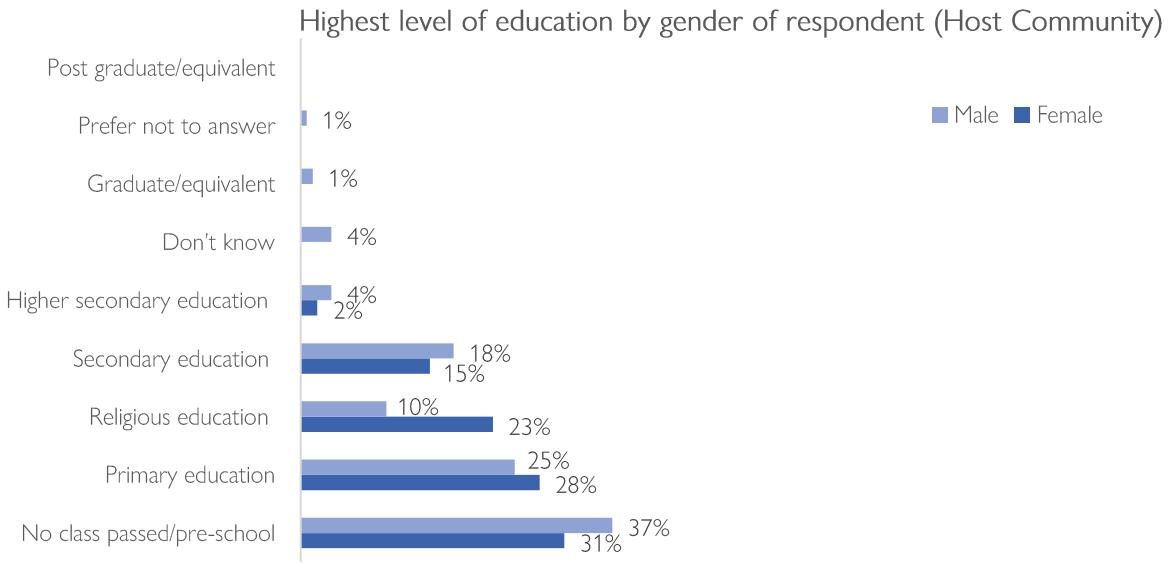
Refugee community:

The majority of the respondents from the refugee community had three children (19.78%), followed by those who had four (19.03%).



Education:

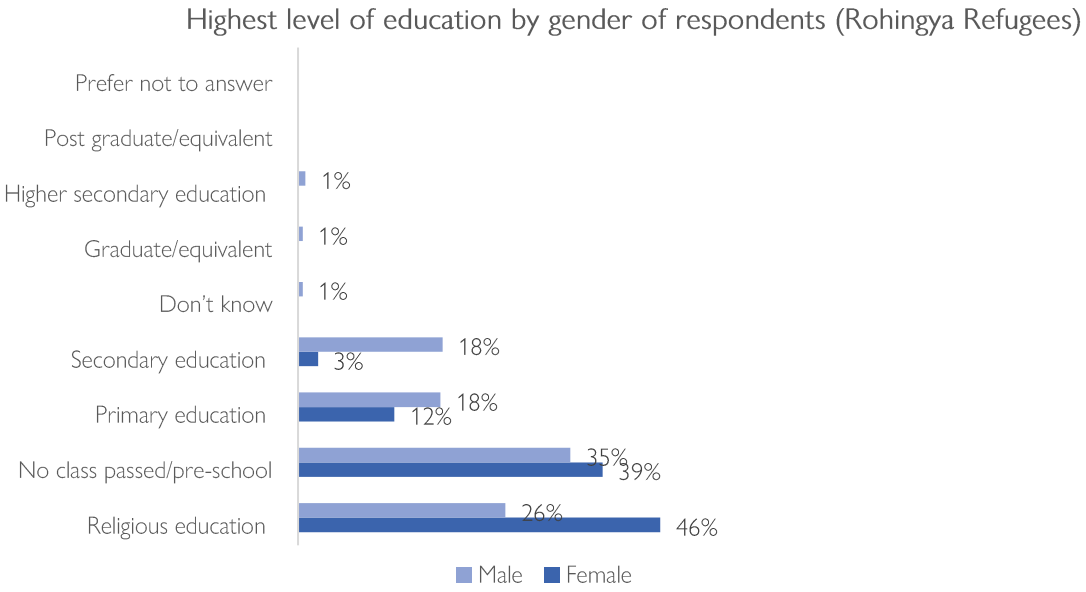
Host community: The majority of respondents did not attend any school or had only pre-school education (33.03%), followed by those who attended primary education (27.42%), religious education (18.88%), secondary education (16.18%), higher secondary education (2.47%), and graduate (0.67%).



Refugees:

The majority of refugee respondents attended religious education (39.06), followed by those who did not attend any class or attended only pre-school (37.31%), primary education (14.33%), secondary education (8.21%), higher secondary education (0.33%), graduate/equivalent (0.22%), postgraduate (0.11%) and the rest didn't know (0.44%). It is worth mentioning that Rohingyas do not have access to the formal education system in Myanmar, a measure that is imposed by the government and is related to the denial of citizenship. Furthermore, they do not have access to the formal educational system in Bangladesh either due to their status as FDMN, i.e. Forcibly Displaced Myanmar National.

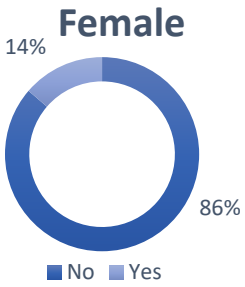
Therefore, many Rohingya refugees focus on religious education that takes place in madrassas (religious schools) within the community in their areas of residence (in Myanmar) and refugee camps (in Bangladesh).

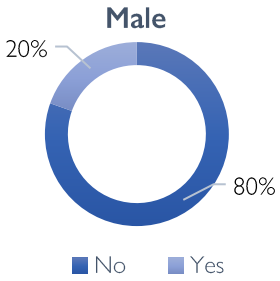


Disability (Households including people with disability):

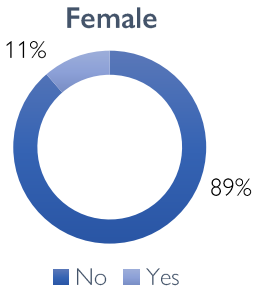
On average, 15.51 per cent of the interviewed host community members had at least one person with disability in their household, while the percentage for the Rohingya refugees was at 13.02 per cent. At this point, it is worth noting that the Washington Group Questions (a set of targeted questions on individual functioning) were not part of the demographics, as lengthy interviews were avoided. The participants had to reply to one question: "Do you have people with disability in your household?". Therefore, the percentage is relevant, as many people do not identify disability as such, unless it is visible and physical.

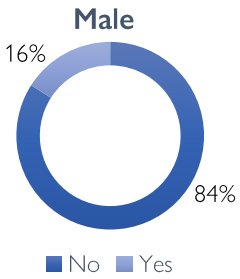
Host community:





Rohingya Refugee community:





14 per cent of the female and 20 per cent of the male participants from the host community shared that they have at least one person with disability in their household. The same percentage for the refugee community was 11 per cent for female and 16 per cent for male respondents.

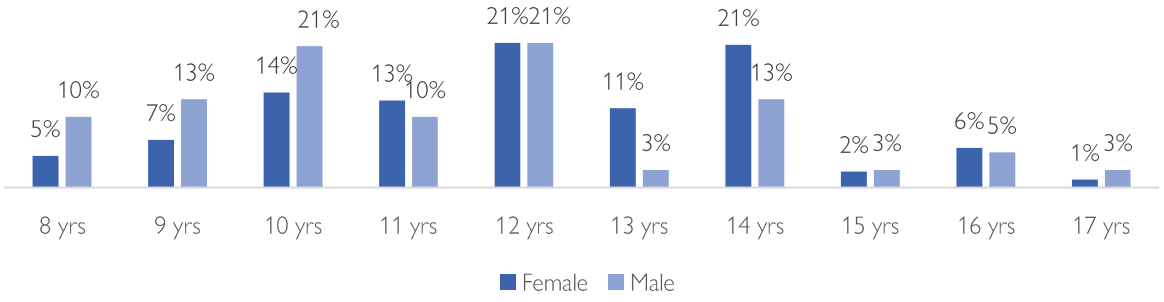
Children demographics:

A total of 394 children participated in the assessment, with 126 originating from the host community and 268 from the Rohingya refugee community.

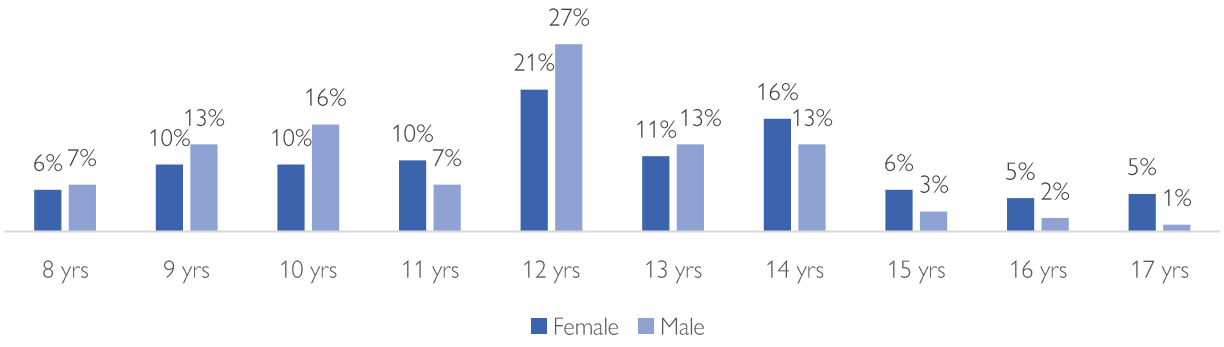
Gender: The majority of child respondents in both groups were girls (69.05% [n=87] of the host and 61.57% [n=165] of Rohingya participants), while boys were represented at 30.95 per cent (n=39) for the host community and 38.43 per cent (n=103) for the refugee community.

Age: The average combined age for the host community children was 11.87 (12.09 for girls and 11.38 for boys) while the average combined age for the Rohingya children was 11.99 (12.25 for girls and 11.56 for boys).

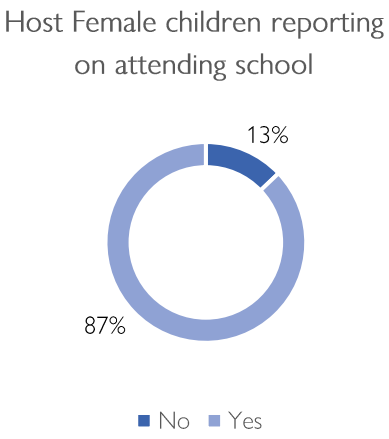
Host community: Age of children who participated in survey by gender of children

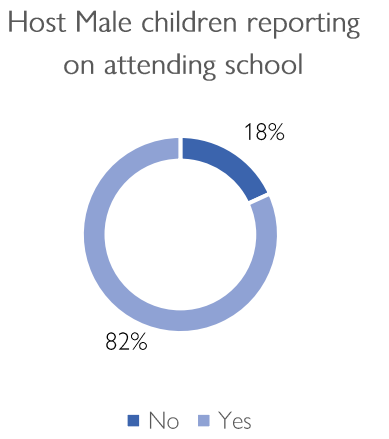


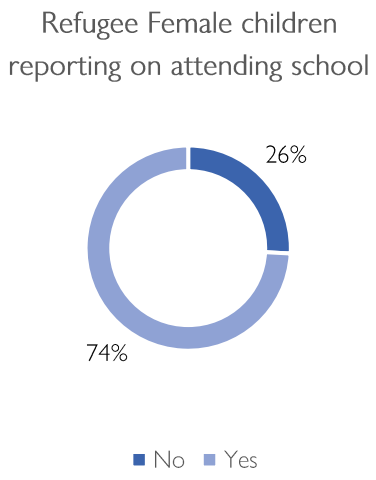
Rohingya refugee community: Age of children who participated in survey by gender of children

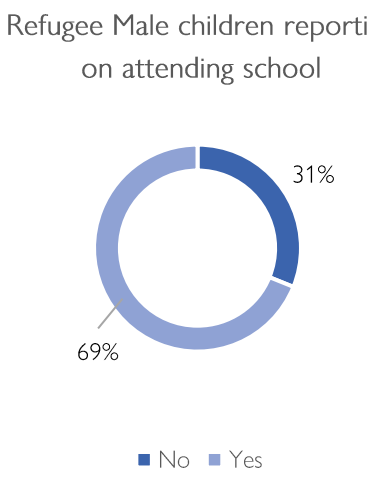


Education:









A higher percentage of refugee children reported not attending school (26% of girls and 31% of boys, while the percentage of the host girls was 13% and boys 18%). In both groups, boys tend to report not attending school more often than girls.

© Focus Group Discussion session in Shamlapur host area, IOM, Cox's Bazar, Bangladesh, Mashrif Abdullah Al

Demographic information of Focus Group Discussions participants:

A total of 18 FGDs took place between December 2020 and February 2021 with participants from the two communities. As it is explained below (look "Ethical considerations"), the moderators were not asking for any information that could lead to the identification of the persons, to avoid any negative consequences for future relocation procedures.

In total, 231 persons participated, with 73.2 per cent (n=169) from the refugee community and 26.8 per cent (n=62) from the host community. The sessions were facilitated separately for the two communities and a gender segregation for both groups were also in place.

Gender:

Women 107 (host: 36, Rohingya: 71); Men 124 (host: 26 Rohingya: 98)

Among the participants, 71.86 per cent (n=166) were adults (female: 68 [host: 12, Rohingya: 56], male: 98 [host: 26, Rohingya: 72]); 28.13 per cent (n=65) were adolescents (female: 39 [host :24, Rohingya:15], male: 26 (host: 0, Rohingya: 26)

Capacity building:

The enumerators of the quantitative part and the facilitators of the FGDs were trained on the use of the tools that were chosen and developed for this assessment. The MHPSS team cascaded the training to MHPSS volunteers for two days in December 2020. One team leader was assigned for each team, and the teams were

composed by 1 MHPSS staff, 1 NPM staff and 1 MHPSS Volunteer. Every morning the teams had a brief meeting, before being assigned to specific areas. NPM was granted with all the necessary permissions to access the camps for the quantitative part while the FGDs took place in the areas of operation of IOM, and as such no special permission was required.

Data collection:

All data collection took place in person by a team of two (1 MHPSS and 1 NPM staff) with the addition of volunteers to overcome any potential language barriers. All the inputs were made directly on KOBO platform (IOM data toolbox).

Data analysis:

NPM worked on the statistical analysis of the data and the development of graphics, while the MHPSS team worked on the interpretation.

Ethical considerations

The below ethical considerations were taken seriously during the design and implementation of the assessment exercise to ensure the "Do no harm" principle:

- Voluntary participation of respondents: All the participants were informed of the purpose of the assessment and their right to withdraw any time if they wished to. For those who agreed to participate, a verbal consent was obtained. There were no incentives given to people participating in the assessment, and no negative consequences for those who decided not to participate.

- Participation of children: Children between 8 and 17 years old participated in the first part of the assessment. The verbal consents of the parents were obtained, and the interviews took place in their households, in the presence of the caregiver. In addition, only enumerators who are trained to work with children could perform this task. To ensure that the scale for children (see below) was appropriate for the targeted population, the IOM Child Protection team was requested to review the chosen questions.

- Confidentiality: Confidentiality was ensured in all the interviews by not requesting personal information that could lead to the identification of any of the respondents. For example, name and specific location (such as block and sub-block) were not recorded. During the data collection, the teams ensured that the interviews were taking place in a safe place and the presence of bystanders was avoided. Additionally, all the documents were safely stored.

  It is worth mentioning that the assessment exercise took place during a turbulent period, with widespread fears among the refugee community for the relocation to Bhasan Char Island. To avoid raising any suspicion, the purpose of the assessment was well explained, and all the identifiers were removed from the demographic questions.

- Cultural adaptation of the tools: Given that there is a limited validity of psychological scales for both the host and refugee communities, IOM performed some FGDs with people of concern and MHPSS volunteers to check the validity of the chosen tools. After teams collected the initial information, some scales were modified based on the need of validity adaptation. Additionally, questions that could potentially be misinterpreted, cause emotional reactions or be even re-traumatizing, were intentionally avoided. Local concepts of mental health as well as idioms related to mental health were also taken in consideration and the teams were trained on using specific terms in Rohingya language based on the recommendations of "Culture, Context, and Mental Health of Rohingya Refugees" tools, that were published by UNHCR. Lastly, MHPSS volunteers supported with the translation during the assessment exercise to ensure a proper communication and accurate translation between interviewers and interviewees.

- Cultural context: MHPSS volunteers accompanied the teams during the data collection, ensuring that the language barriers would be overcome. The tools were translated by the CwC (Communication with Communities) unit, and the translation was cross-checked by three Bangladeshi MHPSS experts.

- Identification of needs: The team was trained to perform the interviews without using any diagnostic criteria but to refer to other services in case they encounter respondents in need of services or provided Psychological First Aid (PFA) and basic emotional support themselves whenever needed.

- Gender considerations and gender diversity: All the teams were composed by a male and a female enumerator, ensuring that all the teams were gender balanced.

- Inclusion of different groups: This was attempted at all stages of the assessment, such as different age groups, including youth and older adults, and other groups traditionally considered as more vulnerable (people with disabilities, pregnant women, people with mental health conditions, etc.).

- Mitigation of tiredness of the respondents: This was addressed by ensuring that the interviews and data collection did not take more than 30 minutes for each respondent and the FGDs did not exceed 1.5 hours per session.

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Quantitative component of the assessment:

The questionnaire that was developed to collect quantitative data for this assessment, was composed by six IASC validated scales. Two separate questionnaires were created for adults (18+) and children/youth (12-17 years old). It is noteworthy that the chosen scales were not previously validated in Bangladesh (nor in Myanmar for the Rohingya population). Therefore, IOM conducted four FGDs prior to the assessment to pilot the tools and ensure that the scales are appropriate for the specific context. During these FGDs, information regarding idioms and specific cultural-linguistic expressions were also collected and registered. After the initial FGDs for the validation of the tools, some slight modifications were made to the scales to ensure the contextual adaptation of the questions. The scales were then translated and cross-checked by three experienced MHPSS practitioners with degrees in Psychology to ensure that the translation is as accurate as possible.

The scales assess the perceived signs and levels of depression, anxiety, and stress, impacting the psychosocial well-being of the respondents, as well as protective factors, such as resilience and social support resources. The replies were recorded on Likert scales (from 1: not at all / strongly disagree to 5: a lot / strongly agree).

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Note: the assessment did not have any diagnostic goal; the aim was to gain a better understanding of the psychosocial situation of the refugee and host communities using the scales below.

The use of scales is summarized in the table below:

Adults (18+ y/o), 32 questions:

- Eight demographic questions
- Scales (Likert scale responses):
- PHQ-9 Patient Health Questionnaire (9 questions and 1 optional).
- GAD-7 Generalized Anxiety Disorder (7 questions)
- PSS-4 Perceived Stress Scale (2 questions were extracted out of 4)
- BRS Brief Resilience Scale (2 questions were extracted out of 6)
- OSSS-3 Oslo Social Support Scale (3 questions)

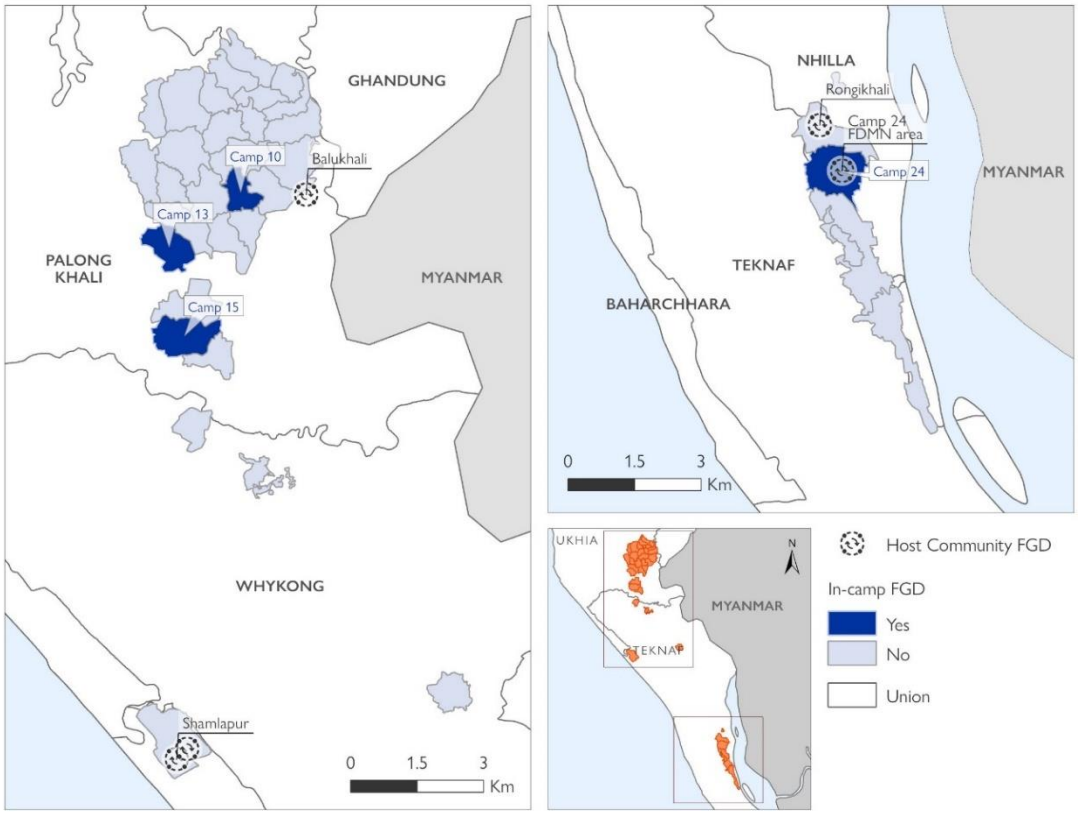
Children (12-17 y/o), 8 questions:

- Three demographic questions
- CPDS – The Child Psychosocial Distress screener (5 questions, Likert scale responses)

Tool	Outcomes assessed	# of items	Estimated time to administer (in minutes)	Comments
ADULTS				
Demographics	General Information	8	2	All the identifiers were removed
PHQ-9	MHPSS difficulties / symptoms related to depression	9 or 10 (1 additional optional question)	5	2 questions (no. 7 and no. 9) were modified to match the cultural context
GAD-7	MHPSS difficulties / symptoms related to anxiety	7	4	The formulation of the questions were slightly modified to match the cultural and living situation of the respondents
PSS-4 Perceived Stress Scale 4	MHPSS difficulties / symptoms related to stress	2 (out of 4)	2	2 out of the 4 questions of this scale were asked
Brief resilience scale	Coping mechanisms	2 (out of 6)	2	2 out of the 6 questions of this scale were asked
Oslo social support	Coping mechanisms	3	3	
CHILDREN/YOUTH				
Demographics	General information	3	3	
The Child Psychosocial Distress Screener (CPDS)	MHPSS difficulties / symptoms	5	5	The formulation of the questions was slightly modified to match the cultural and living situation of the respondents

Qualitative part (Focus Group Discussions):

The participants of the FGDs consisted of adolescents (14-17 y/o) and adults (18+ y/o). Age, gender and origin-based segregated groups were created with an effort to be inclusive and have representatives from all groups (including older adults, people with disabilities, etc.). The sessions were conducted across the two Upazilas of Ukhiya and Teknaf between December 2020 - February 2021.



For the development of the FGD tool, questions from the "IASC Reference Group Mental Health and Psychosocial Support Assessment Guide" (2012) and the "IOM Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return" (2009) guidelines were extracted, alongside questions that were considered as interesting (and culturally appropriate) to ask.The total number of questions was 19 and the predetermined semi-structured interview was divided into four parts:

1. Sources of distress and groups at risk (partially quantitative)
2. Psychological reactions
3. Coping strategies and resilience responses
4. Information on available services and perception of appropriate support

Briefing sessions and written guiding tools were provided to all the facilitators. All the FGDs were led by MHPSS staff (with a facilitator and a note-taker), with the support of MHPSS volunteers to ensure the maximum duration of each session was 1.5 hours. All the information was collected by the MHPSS officer and then compiled and analyzed.

First section: The first section aimed at the most prevalent stressors identified by the participants impacting their psychosocial well-being. A free listing technique was initially used to get an overview of the identified stressors ("1a. What kind of problems do you have (because of the humanitarian situation) that affect the way you feel? Please list as many problems that you can think of at individual, family and community level for women, men and children in your community"). The participants then had to rank according to the statement "1b. From the mentioned problems, what are the biggest problems for you? Please choose 3 each." The note-taker had to list the problems and count the replies / quantify.

In addition, the participants had to identify the groups they considered as more vulnerable, and therefore in need of more/tailored support.

Second and third section: The second and third sections were dedicated to the identified psychological reactions, the perceptions of mental health as well as coping mechanisms and resilience factors. The participant's replies were analyzed in a qualitative way. The questions were related to the consequences of the problems they identified prior on the emotional well-being on individual, family and community level, the perceptions and attitudes towards people with mental health conditions, cultural-specific expressions of distress and preferred sources of support and coping strategies, including traditional rituals.

Based on IOM's multi-dimensional and systemic approach, most of the questions targeted extracting information on three levels: individual, family and community.

Fourth section: The last section aimed to explore the information the respondents have on existing sources of mental health and psychosocial support and perceptions of appropriate support.

FINDINGS OF INDIVIDUAL ASSESSMENTS/ QUESTIONNAIRES

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The results presented below are based on the data that were collected during the quantitative part (questionnaire) of the assessment, featuring the responses of the participants and segregated by host/ refugee and gender (male / female; the option "other" for gender was selected by 0 per cent of the participants, therefore, was not included for data analysis). The primary findings can be found below with a brief analysis at the end of every part.

PHQ-9 scale:

The participants had to choose "Over the last two weeks (14 days), how often have you been disturbed by any of the following problems?"

1. Little interest or pleasure in doing things:

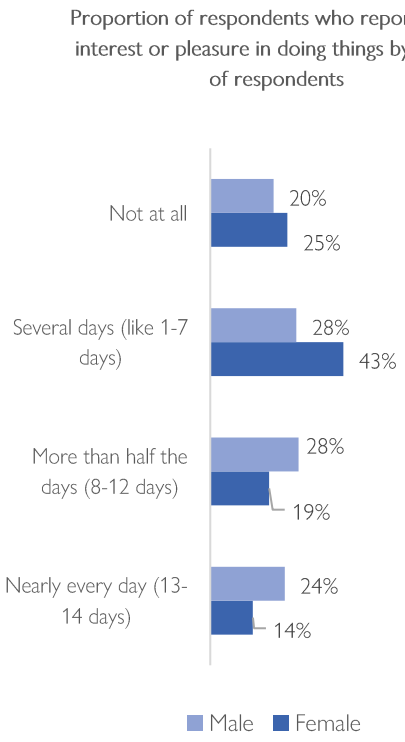

Figure 1a: Host community

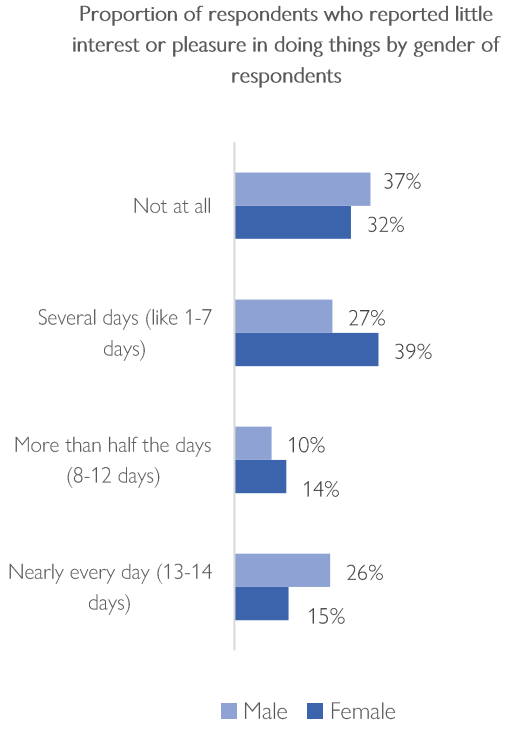

Figure 1b: Rohingya refugee community

Most participants, both Rohingya and Bangladeshi, reported that they had little interest or pleasure in doing things during the last 14 days. In total, 76.63 per cent of the host community and 66.3 per cent of the Rohingya refugees reported having little interest or pleasure in doing things between one and 14 days (several days, more than half of the days, and nearly every day). Men in both groups were more likely to report that they have little interest or pleasure in doing things nearly every day (24% for host community and 26% for the refugees) than women.

2. Feeling down, depressed or hopeless:

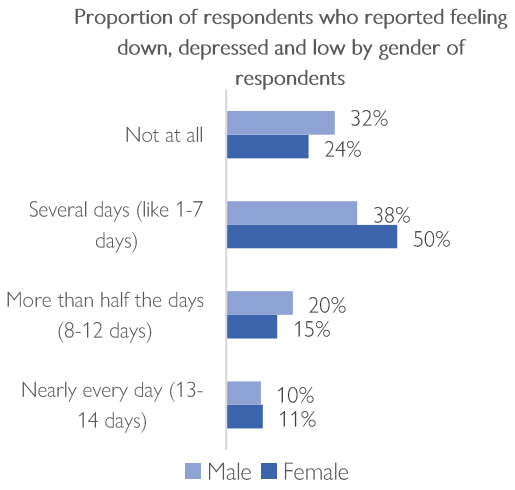

Figure 2a: Host community

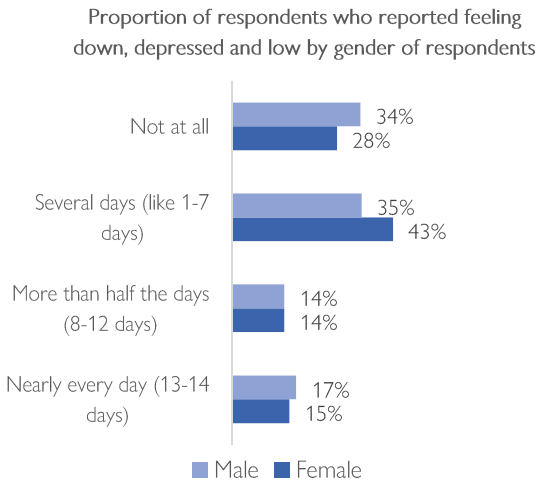

Figure 2b: Rohingya refugee community

During the interviews 10.56 per cent and 15.97 per cent of the respondents from the host and refugee communities respectively reported feeling down, depressed or hopeless nearly every day (the percentage is slightly higher for the refugee community), while the percentage of those who reported having these feelings for at least once in the last 14 days was 73.48 per cent for the host and 69.69 per cent for the refugee respondents.

3. Trouble falling or staying asleep, or sleeping too much:

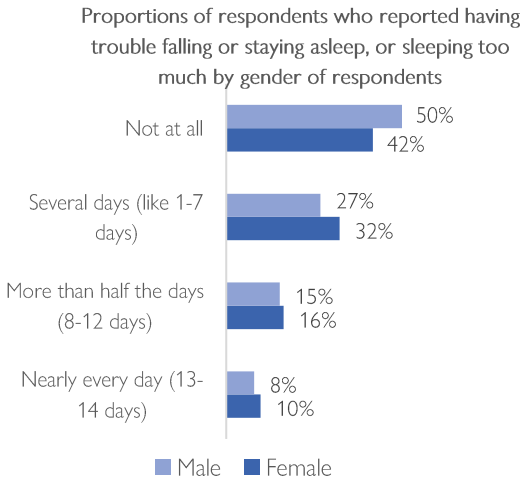

Figure 3a: Host community

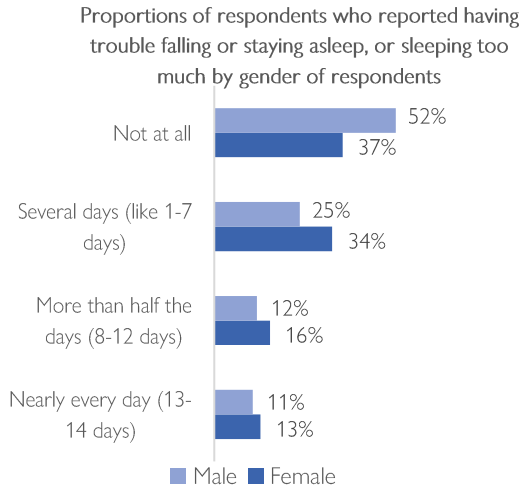

Figure 3b: Rohingya refugee community

While most of the respondents of both communities reported not having troubles falling or staying asleep (44% host and 42.34% refugee participants), the percentage of those who reported having troubles for at least one day in two weeks was 55.53 per cent for the host and 57.66 per cent for the Rohingya. 9.21 per cent of the host and 12.47 per cent of the refugee respondents reported having sleeping disturbances nearly every day. Women in both groups reported experiencing more sleeping problems than men.

4. Feeling tired or having little energy:

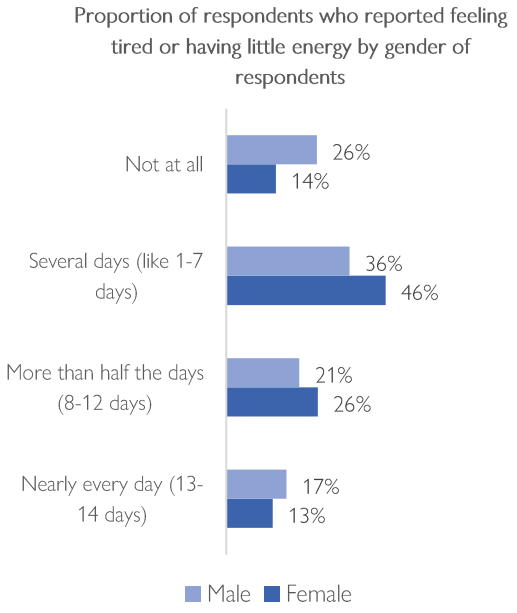

Figure 4a: Host community

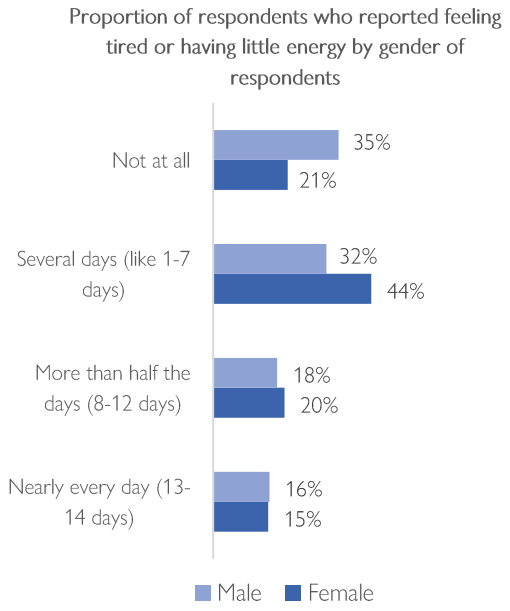

Figure 4b: Rohingya refugee community

Most of the respondents reported feeling tired or having little energy between one and 7 days (42.70% host and 39.61% refugees). It is worth highlighting that the percentage of respondents who reported feeling tired or having little energy between eight and 14 days was 39.33 per cent for the host and 34.58 per cent for the refugee participants. Women reported higher levels of tiredness and lower levels of energy for at least one in 14 days (85% women vs 74% men of the host community and 79% women vs 66% men of the Rohingya group). Host women have the highest score of the four groups.

5. Poor appetite or overeating

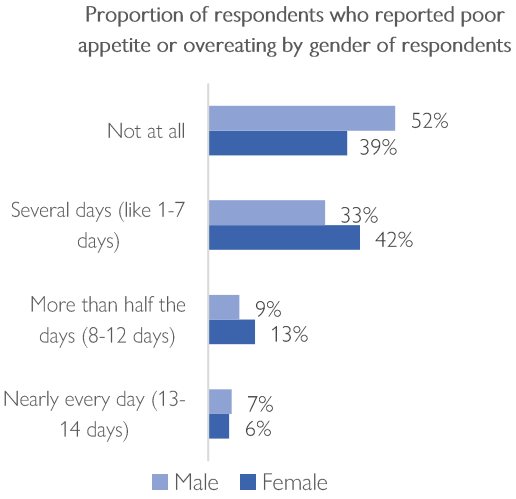

Figure 5a: Host community

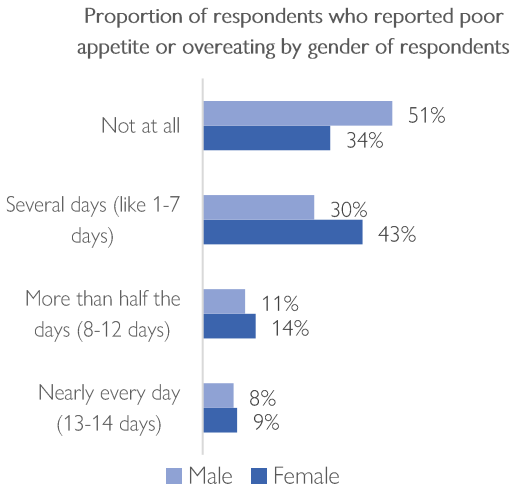

Figure 5b: Rohingya refugee community

Most of the respondents of both communities reported not having poor appetite or overeating during the last 14 days (42.92% host and 39.93% refugee participants). However, the percentage of those reporting having appetite troubles between eight and 14 days was 17.76 per cent for the host and 21.99 per cent for the Rohingya refugee respondents. In addition, more female than male participants reported having poor appetite or overeating.

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family do

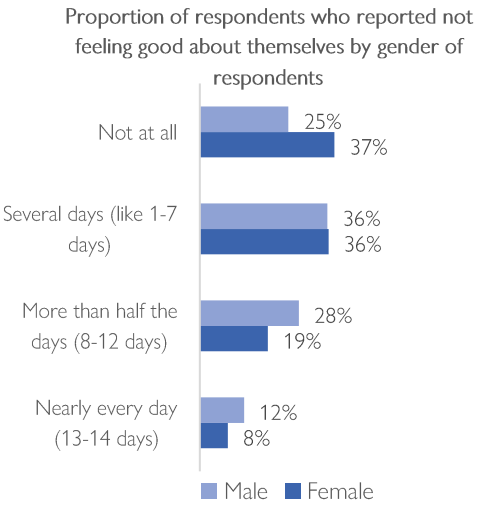

Figure 6a: Host community

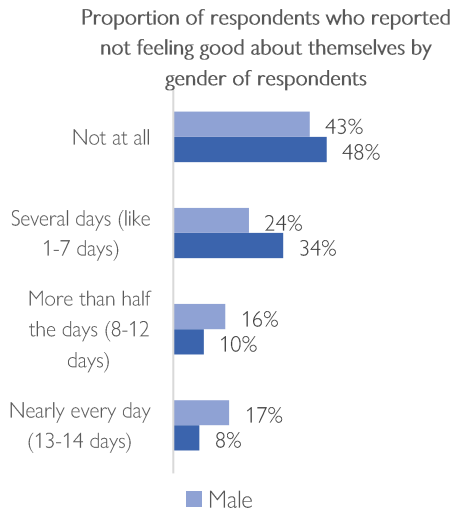

Figure 6b: Rohingya refugee community

Most of the respondents from the host community reported feeling bad about themselves or that they are a failure or have let themselves or their family down on several days (35.73%), while most of Rohingya refugees reported not having this feeling at all (46.06%). The percentages of those reporting having this feeling for more than half of the days were 30.78 per cent for the host community and 23.42 per cent for the refugee and higher for men of both groups.

7. Trouble concentrating on things, such as reading (like the Quran or any other religious book), reciting Quran (if relevant), sewing, doing calculations.

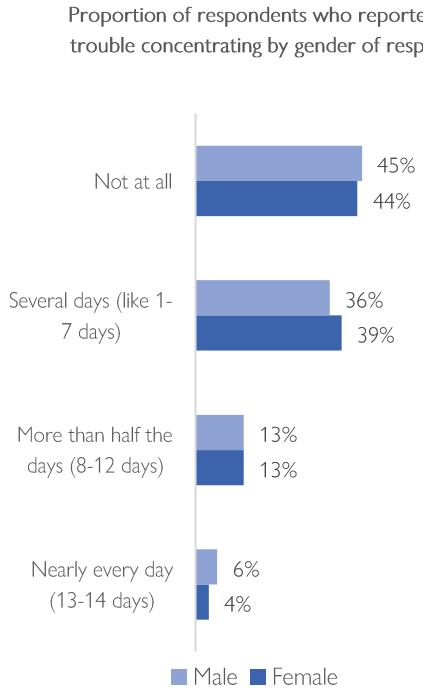

Figure 7a: Host community

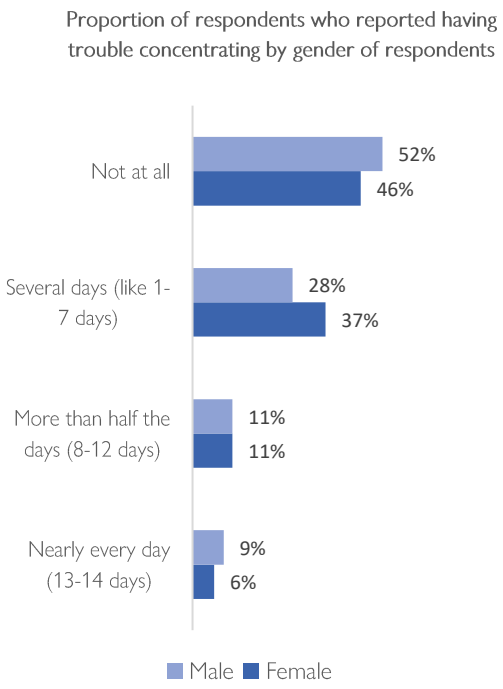

Figure 7b: Rohingya refugee community

A total of 44.04 per cent of the host and 48.58 per cent of the refugee respondents reported not having concentration-related troubles, however, most of the samples reported having such difficulties between one and 14 days (55.96% of the host and 51.42% of the refugee participants). No major differences were observed between the two communities and the two genders.

8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so restless that you have been moving around a lot more than usual

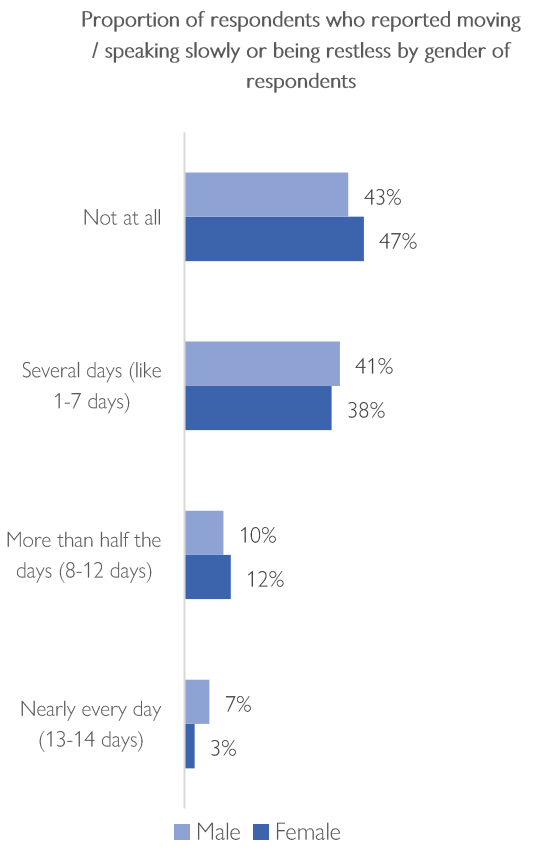

Figure 8a: Host community

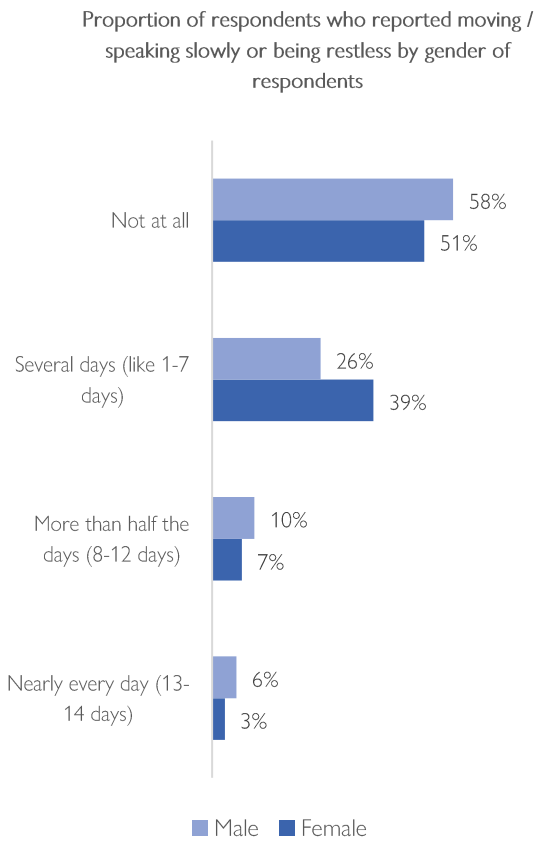

Figure 8b: Rohingya refugee community

Host community respondents reported at 45.62 per cent not having issues "moving or speaking so slowly that other people could have noticed? Or the opposite - being so restless that you have been moving around a lot more than usual", while the percentage of Rohingya was at 53.50 per cent. Nevertheless, the percentages of those reporting having such challenges between one and 14 days were at 54.38 per cent (host) and 46.5 per cent (refugees).

9. Thoughts that you don't want to continue living

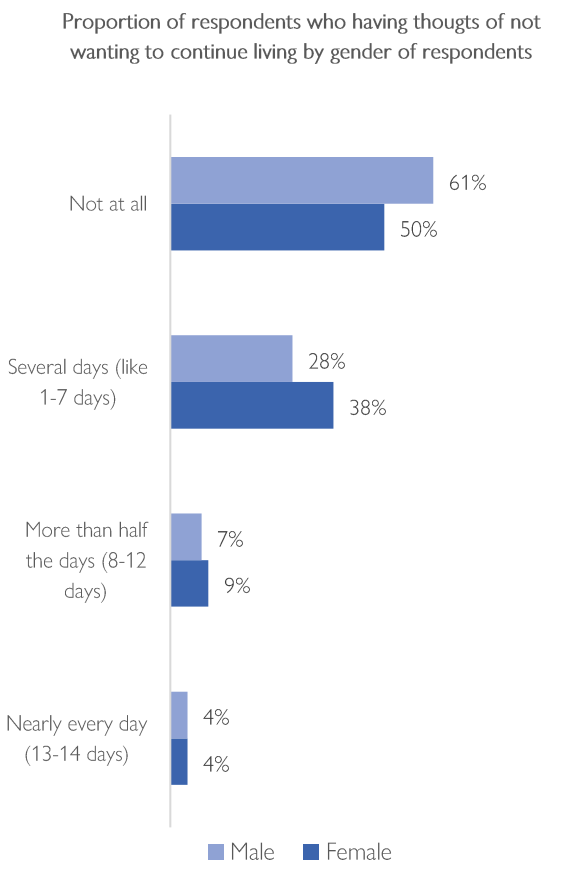

Figure 9a: Host community

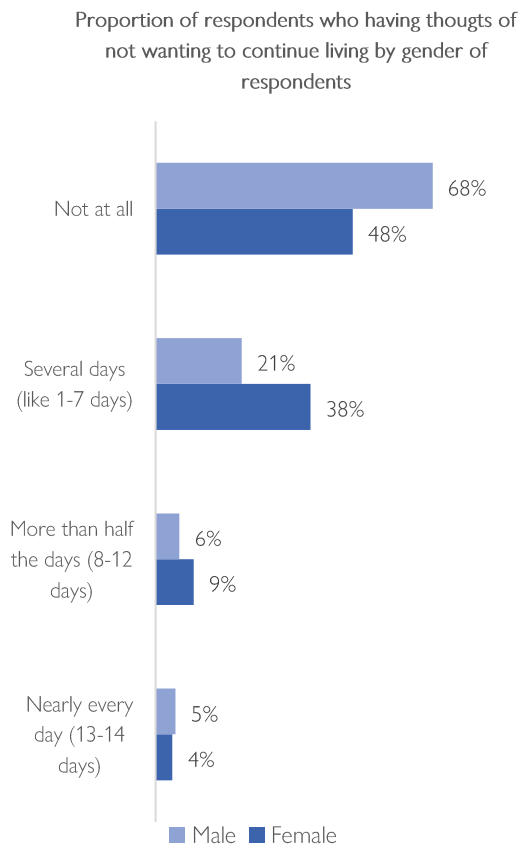

Figure 9b: Rohingya refugee community

Most participants from both communities replied not having thoughts of ending their life at all (53.03% host community, 55.47% Rohingya community). However, the percentage who reported having these thoughts for at least one in 14 days at 46.97% for the host and 41.53% for the refugee respondents). During the exercise 3.82 per cent of the host and 4.38 per cent of the Rohingya participants reported thinking of not wanting to continue their lives nearly every day. It is worth noting that women, overall, are more likely to have thoughts of not wanting to carry on living than men.

10. *If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

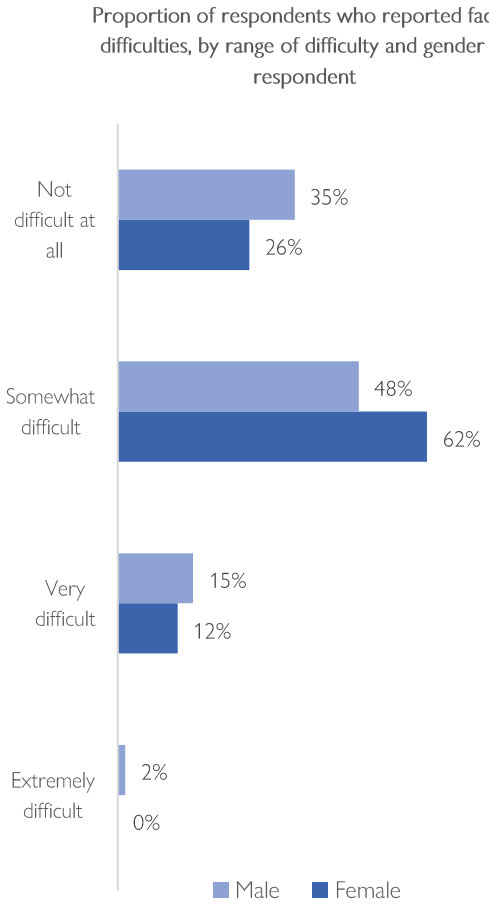

Figure 10a: Host community

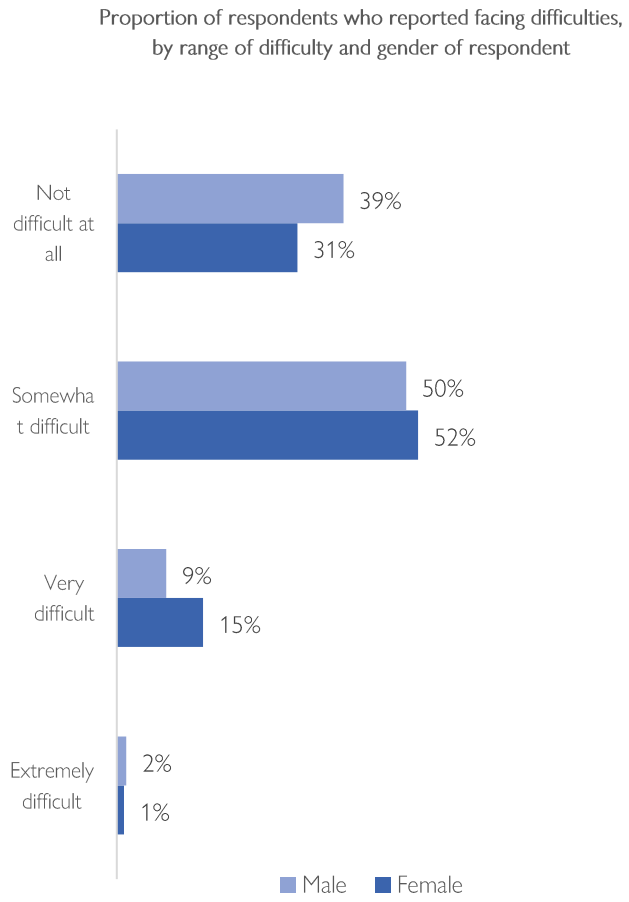

Figure 10b: Rohingya refugee community

This question was asked only to the respondents who replied experiencing at least one of the symptoms of the previous nine questions of this scale. For the majority of those who reported facing any of the above problems, it was "somewhat difficult" (57.51% of the host and 51.67% of the refugee participants) to do their work, take care of things at home, or get along with other people.

GAD-7

1. Feeling tension or nervousness

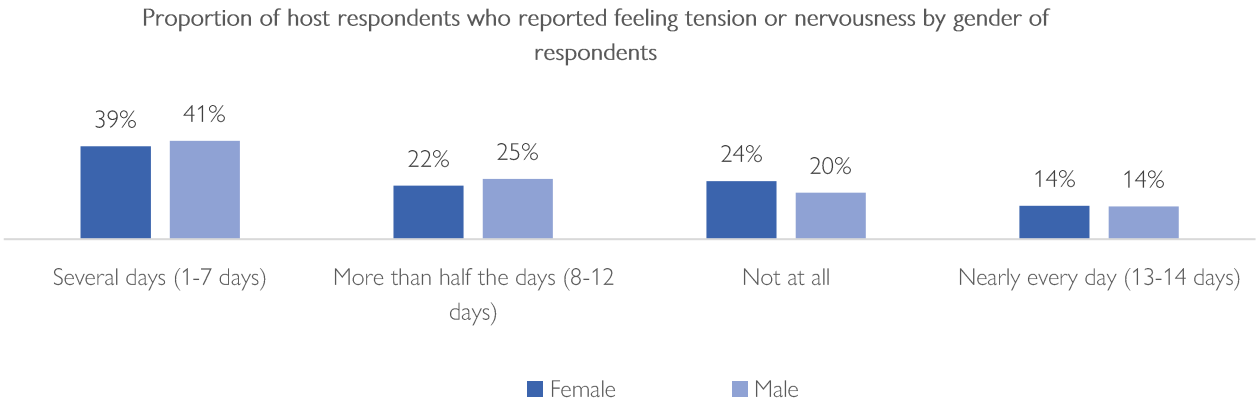

Figure 1a: Host community

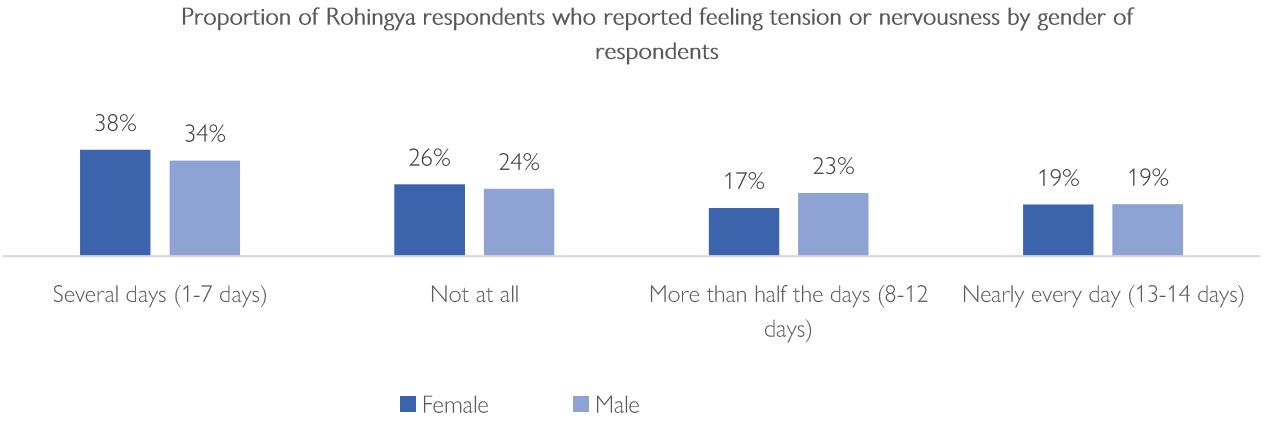

Figure 1b: Rohingya refugee community

Most of the respondents of both communities reported feeling tension or nervousness on several (1-7) days (39.78% of the host and 36.87% of the refugee participants). The percentage of those feeling tension or nervousness between eight and 14 days was at 37.03 per cent (host) and 37.86 per cent (refugee) of the respondents while the total percentage of those experiencing tension or nervousness for at least one in 14 days is at 77.08 per cent for the host community members and 74.73 per cent for the Rohingya refugees. The feeling of tension is almost equally distributed among men and women.

2. Not being able to control worrying

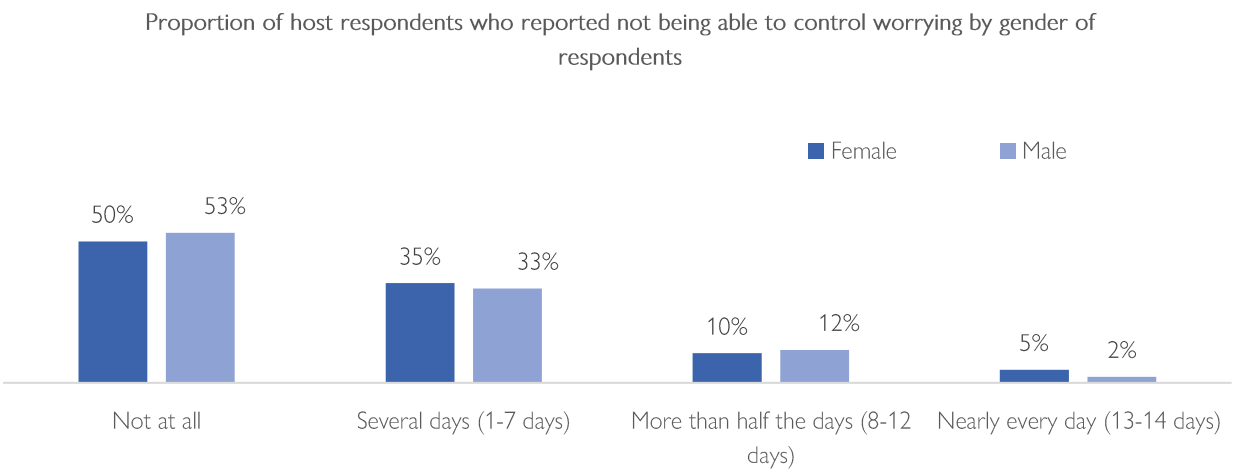

Figure 2a: Host community

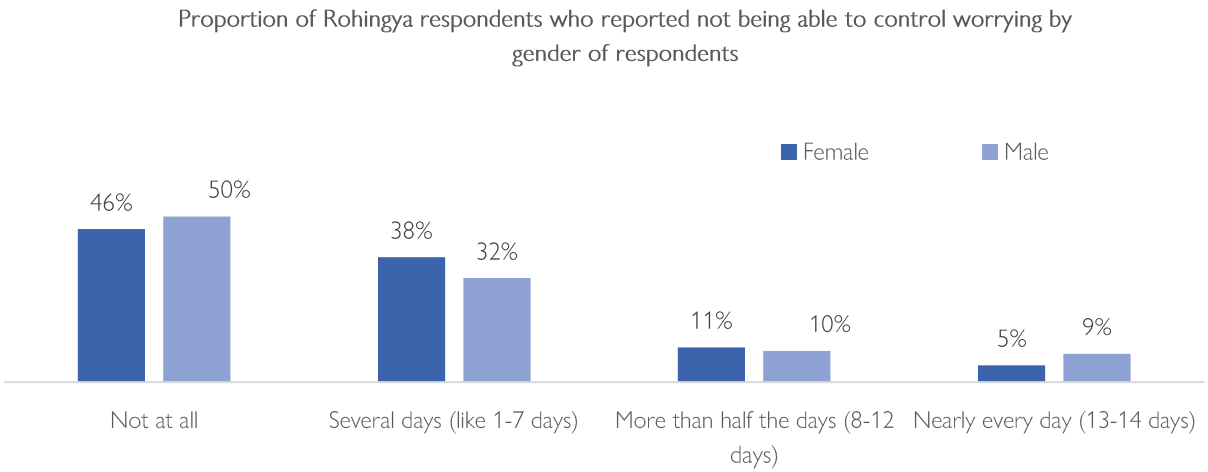

Figure 2b: Rohingya refugee community

Most of the host respondents reported "not at all" (50.79%), however, 49.21 per cent reported not being able to control worrying between 1 and 14 days during the last two weeks. The same percentages for the Rohingya refugee respondents were at 47.81 per cent (not at all) and 52.19 per cent (not being able to control worrying between 1 and 14 days during the last two weeks).

3. Thinking too much about bad things

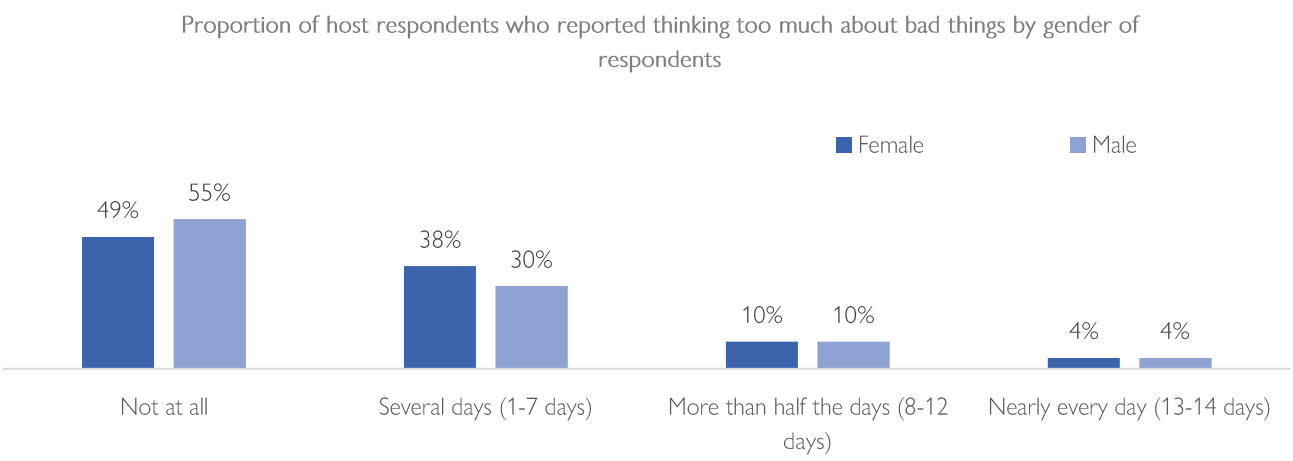

Figure 3a: Host community

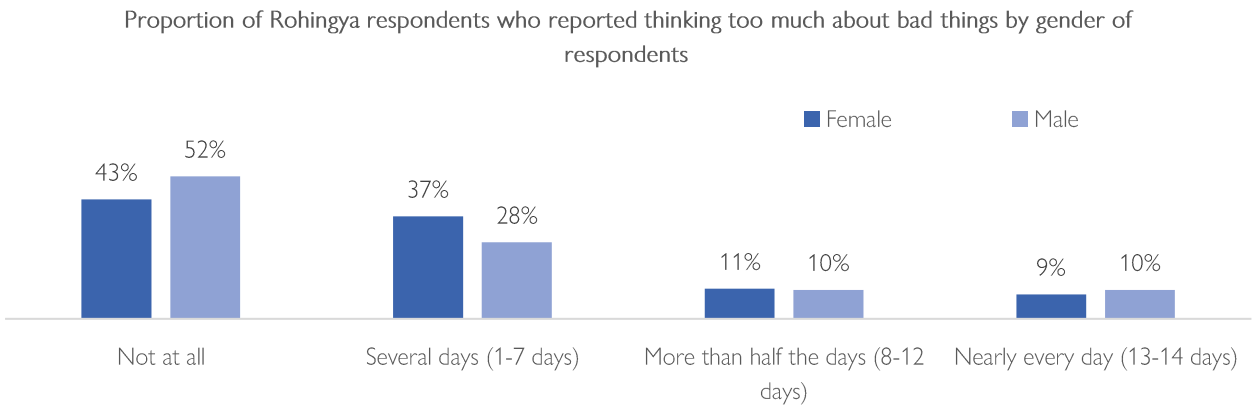

Figure 3b: Rohingya refugee community

While 50.56 per cent of the host respondents and 46.17 per cent of the refugee respondents reported "not at all", thinking bad things, the percentage of those who were thinking too much about bad things between one and 14 days was at 49.44 per cent for the host and 53.83 per cent of the refugee participants (with a higher percentage for women).

4. Trouble relaxing

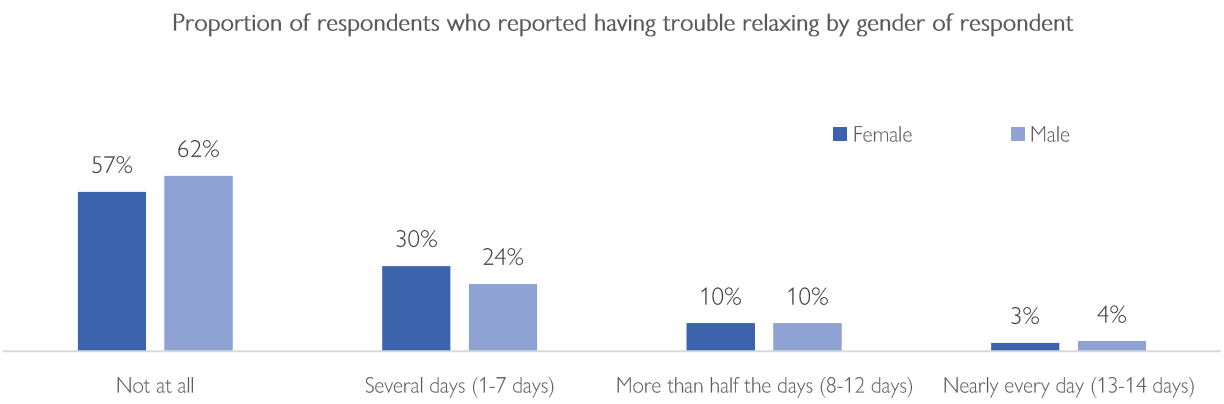

Figure 4a: Host community

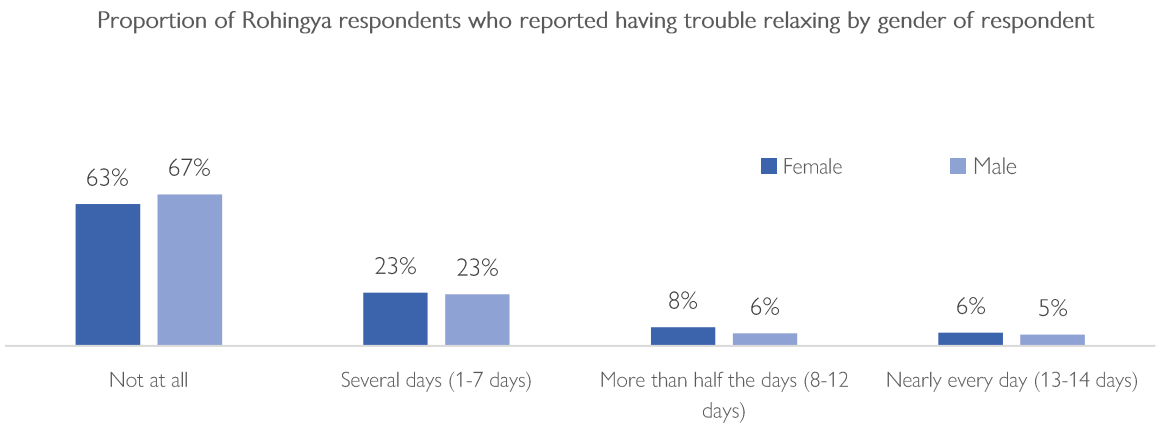

Figure 4b: Rohingya refugee community

Both groups reported mostly not having trouble relaxing (58.43% of the host and 64.11% of the refugee communities). 41.57 per cent of the host community sample reported having troubles relaxing between one and 14 days within the last two weeks, while the same percentage for the refugee community was at 35.89 per cent. Men tended to report more often than women not having this trouble.

5. Being so restless that it's hard to sit still

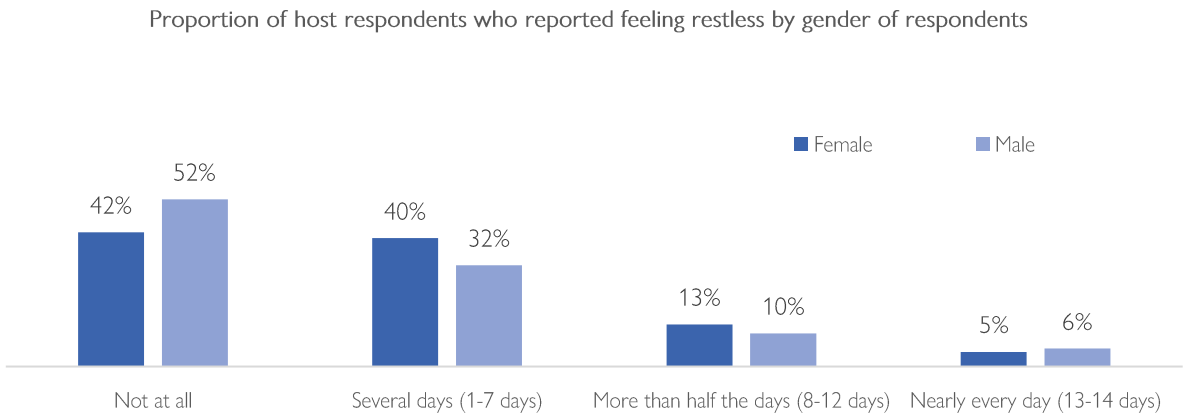

Figure 5a: Host community

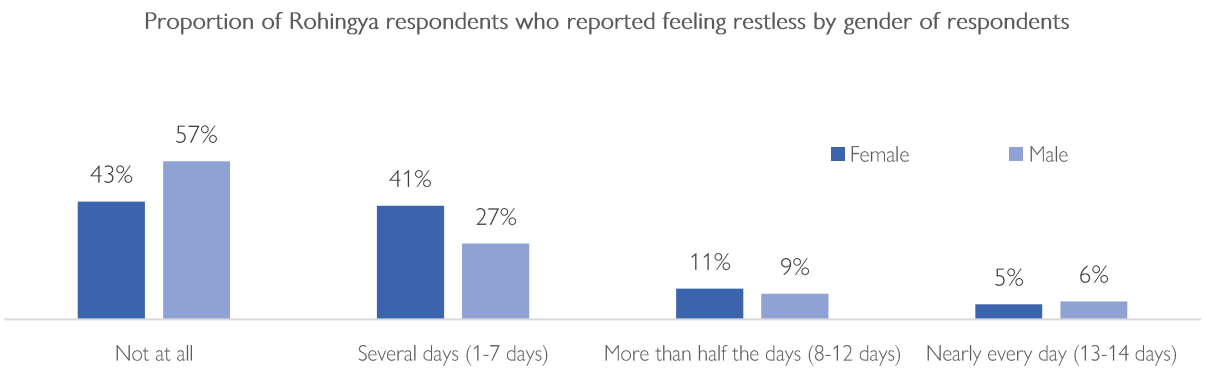

Figure 5b: Rohingya refugee community

Most of host (45.55%) and Rohingya participants (47.70%) reported not at all "being so restless that it's hard to sit still", while the percentage of those who reported having this trouble for at least one in 14 days was 54.45 per cent for the host and 52,30 per cent for the Rohingya respondents. Men reported more frequently than women not having this trouble at all.

6. Becoming easily annoyed or irritable

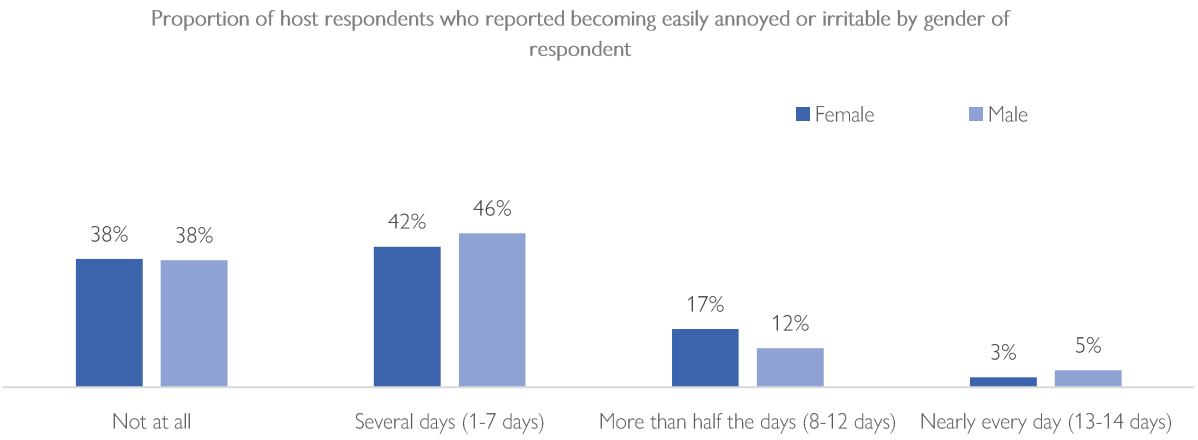

Figure 6a: Host community

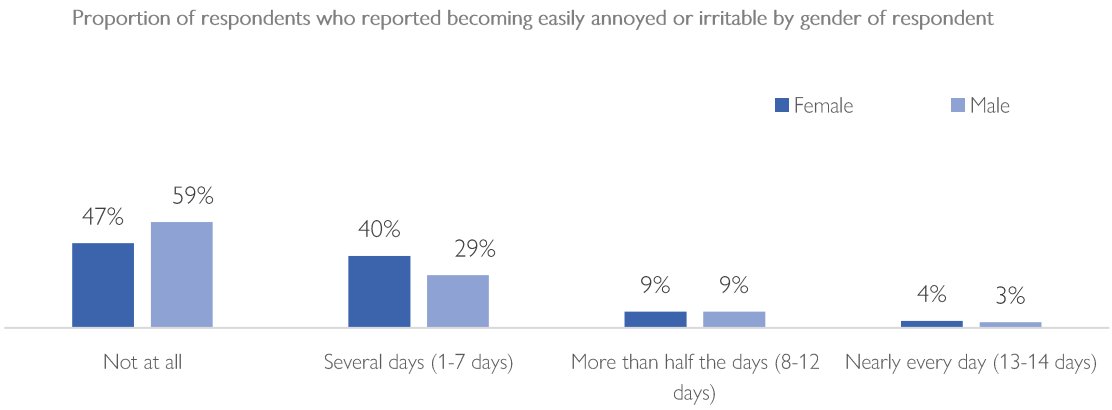

Figure 6b: Rohingya refugee community

The host community respondents reported becoming easily annoyed or irritable on several days (42.9%), while Rohingya refugees prioritized the "not at all" option (51.09%). For both groups, the percentage of those who reported becoming easily annoyed or irritable between one and 14 days was at 62.1 per cent for the host and 48.91 per cent for the Rohingya group.

7. Feeling afraid as if something awful might happen

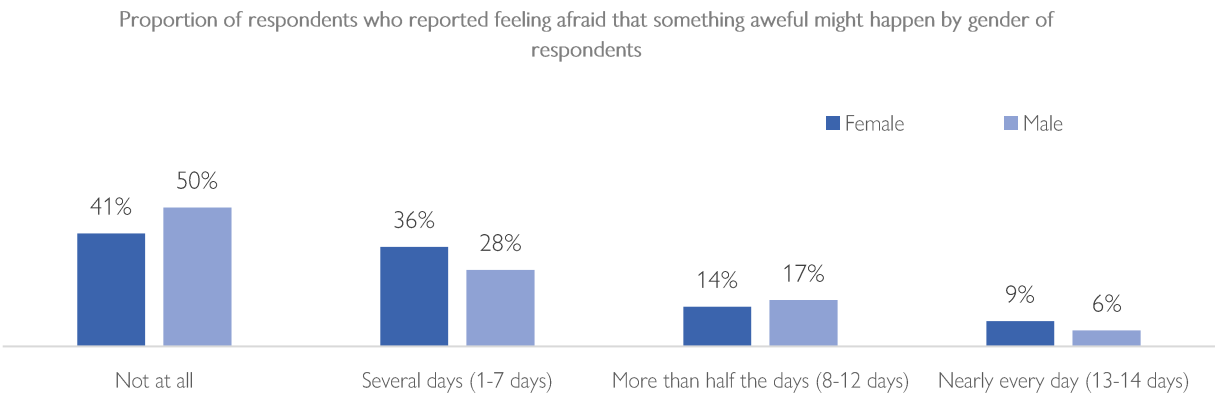

Figure 7a: Host community

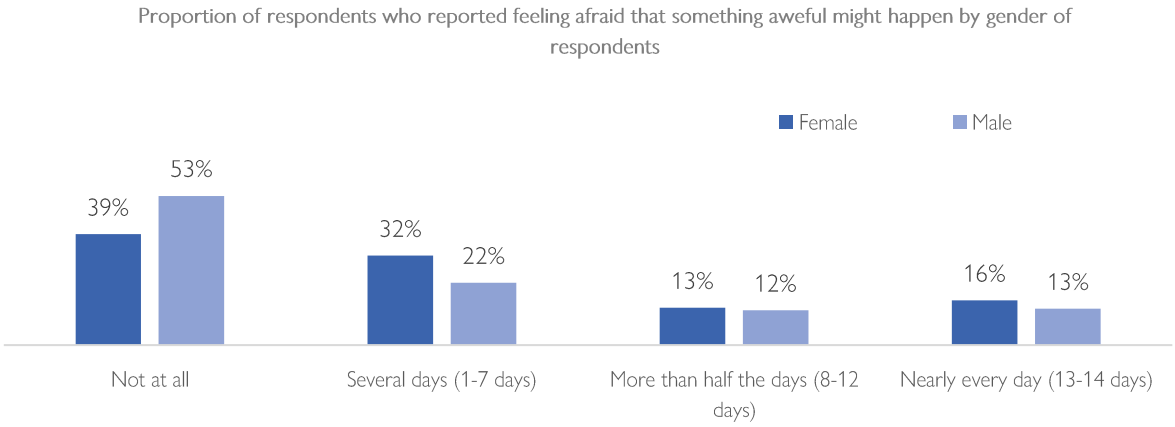

Figure 7b: Rohingya refugee community

A total of 43.60 per cent of the host and 44.09 per cent of the refugee groups reported not feeling afraid that something awful might happen. The percentage for those who reported having this feeling between one and 14 days was at 56.40 per cent (host) and 55.91 per cent (refugees) with women from both groups reporting this more often than men. It should be emphasized that 8.09 per cent of the host and 14.77 per cent of the Rohingya participants reported feeling afraid that something awful might happen nearly every day (13-14 days).

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Questions extracted from the

PSS-4 perceived stress scale 4

1. In the last two weeks, how often have you felt that you were unable to control the important things in your life?

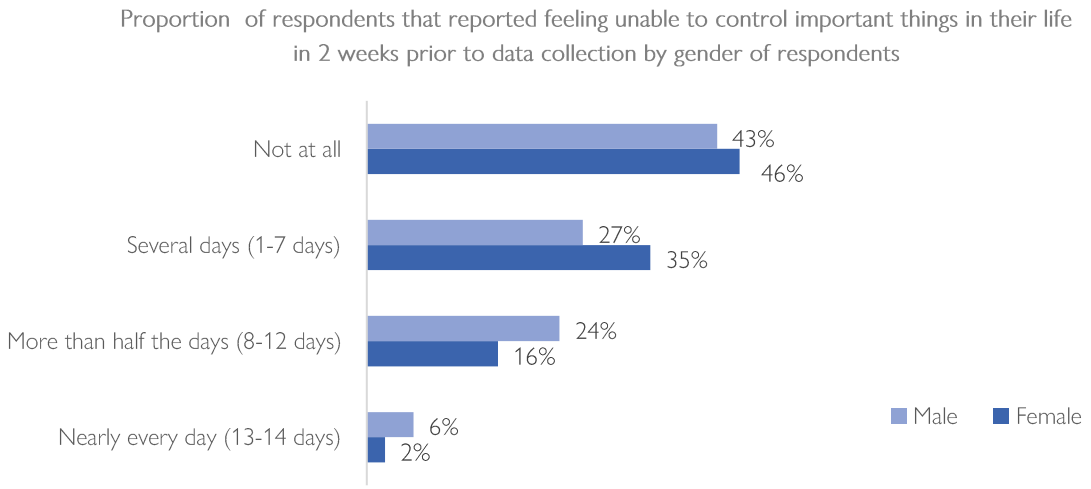


Figure 1a: Host community

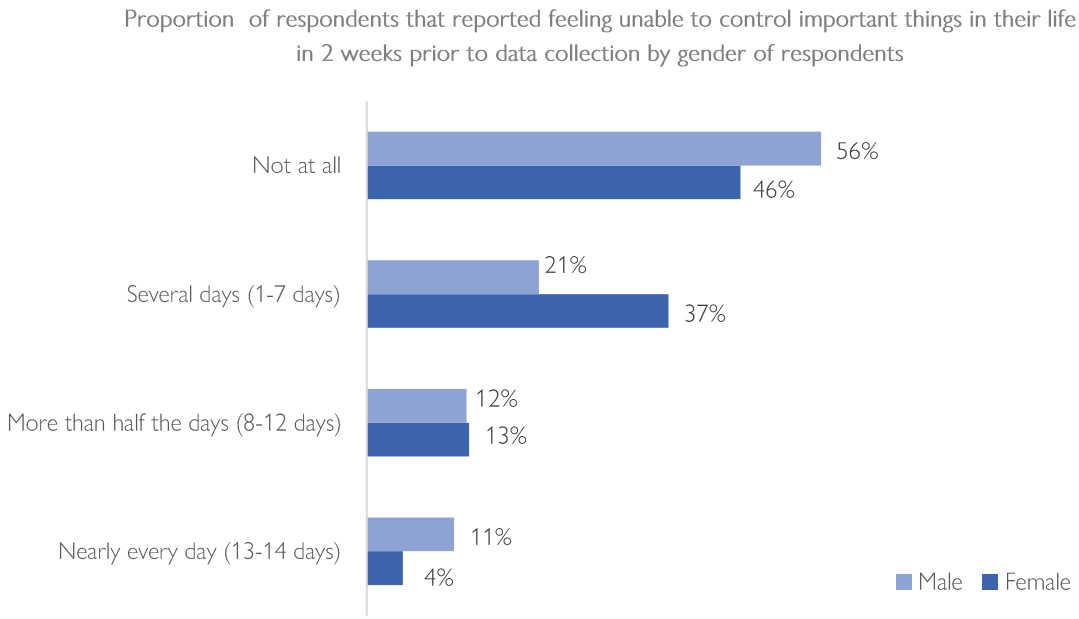


Figure 1b: Rohingya refugee community

It was found that 45.39 per cent of the host and 49.45 per cent of the refugee respondents reported not feeling unable to control important things in their life, while those who did feel unable to control important things in their life during the last two weeks (between 1 and 14 days) was at 54.61 per cent for the host and 50.55 per cent for the refugee group. It is interesting to stress that the percentage of Rohingya participants who reported having this feeling nearly every day was almost the double, in comparison with the host community (3.37% host vs. 6.67% Rohingya). The gender was also an important factor, as men in both groups reported more often than women at feeling unable to control important things in life nearly every day (host community: 2.28% of women and 5.80% of men, Rohingya refugees: 4.42% of women and 10.74% of men).

2. In the last two weeks, how often have you felt you had so many difficulties that you could not overcome them?

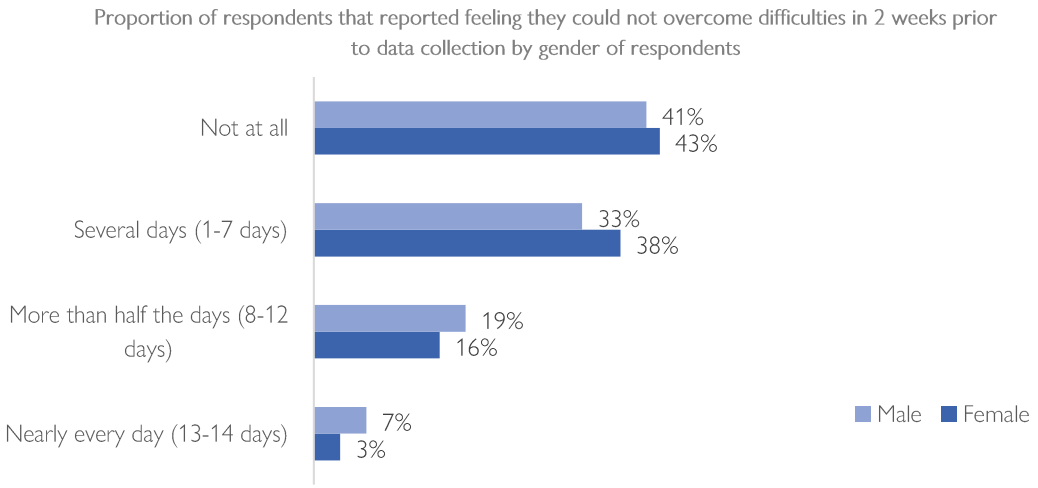


Figure 2a: Host community

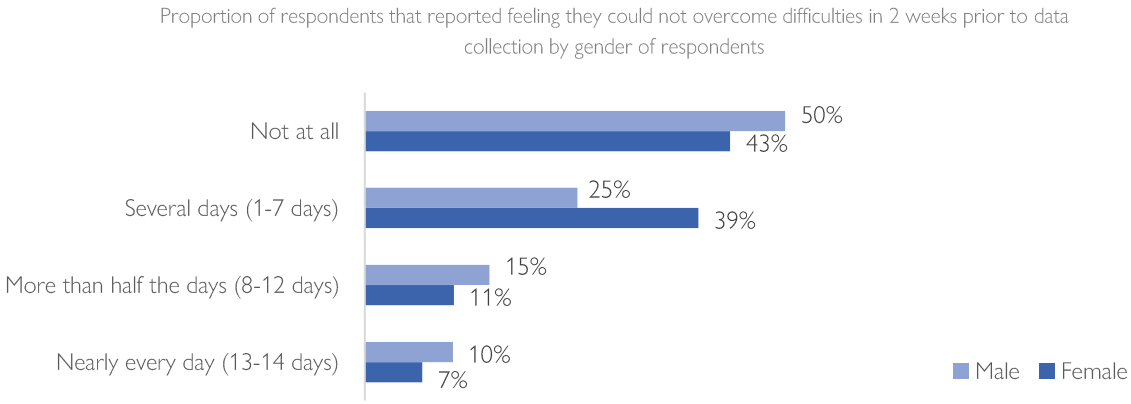


Figure 2b: Rohingya refugee community

Roughly 42.47 per cent of the host and 45.51 per cent of the Rohingya refugee respondents chose "not at all" for the question on whether they felt that they could not overcome difficulties during the last two weeks. The percentage for those who replied positively between one and 14 days was 57.53 per cent for the host and 54.49% for the refugee communities. Men tended to reply more frequently than women having this trouble for at least eight in 14 days, (25.36% of the host and 25.15% of the Rohingya male respondents).

Questions extracted from

BRS brief resilience scale

1. I tend to be able to continue my life quickly after hard times, such as stressful events

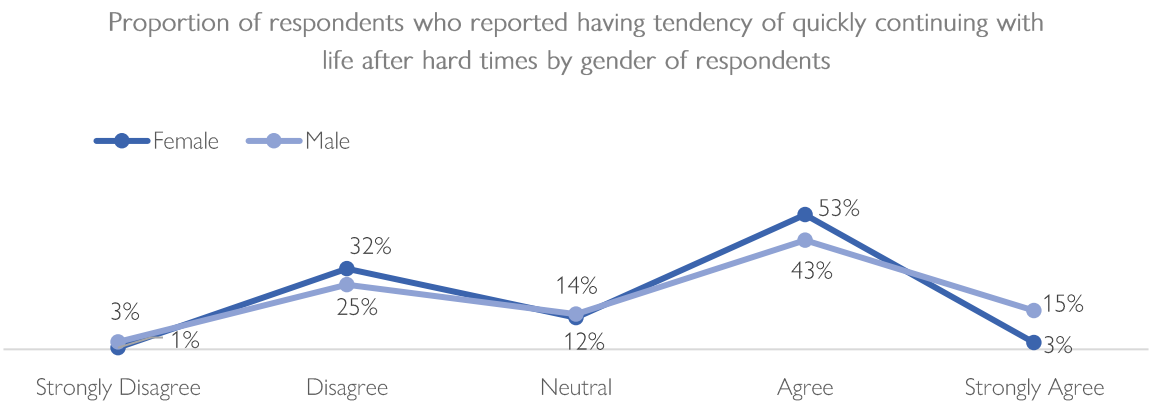


Figure 1a: Host community

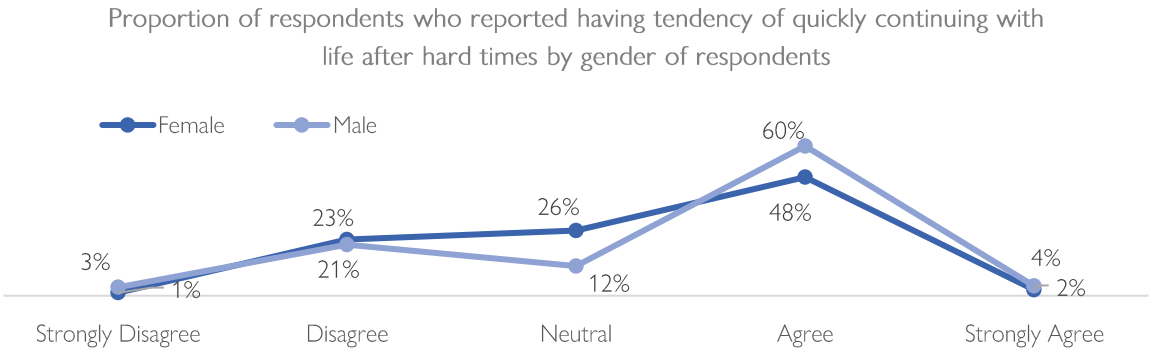


Figure 1b: Rohingya refugee community

Around 49.66 per cent of the host and 52.08 per cent of the refugee respondents agreed with the statement "I tend to be able to continue my life quickly after hard times, such as stressful events", suggesting the adoption of resilient coping mechanisms. The percentage of those who disagree/ strongly disagree was at 28.01 per cent for the host and 23.85 per cent for the Rohingya participants, indicating that a big percentage faces challenges continuing with their lives after hard times.

2. I have a hard time making it through stressful events

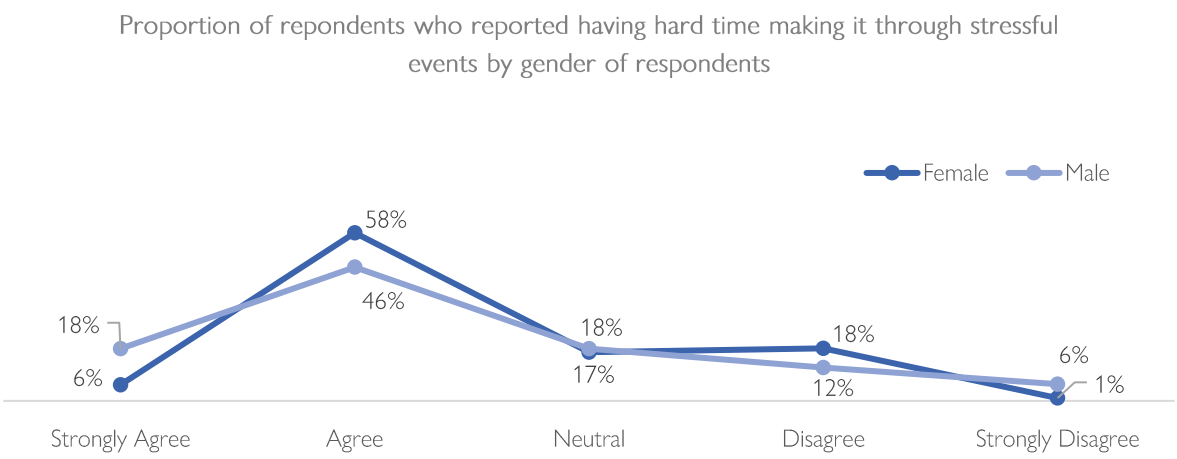


Figure 2a: Host community

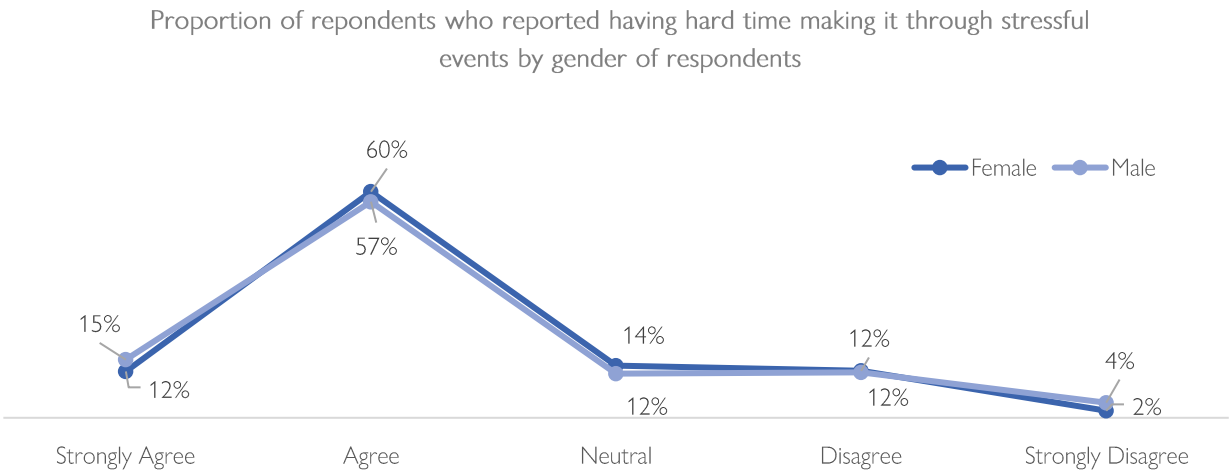


Figure 2b: Rohingya refugee community

Most of respondents of both groups agreed that they have a hard time making it through stressful events (54.61% of the host and 58.75% of the refugee participants), with no significant variation between the two genders.

OSSS-3- OSLO SOCIAL SUPPORT SCALE

1. How many people are so close to you that you can count on them if you have great personal problems?

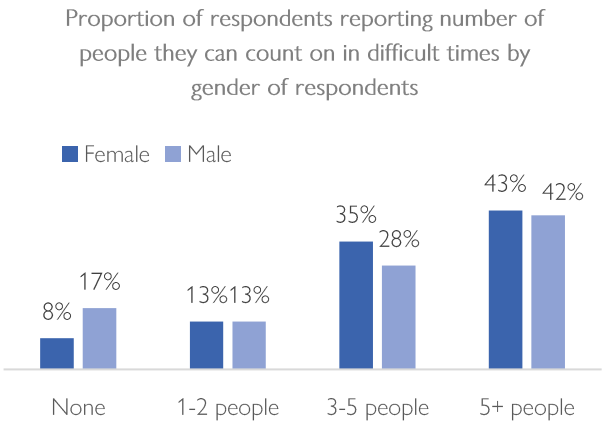


Figure 1a: Host community

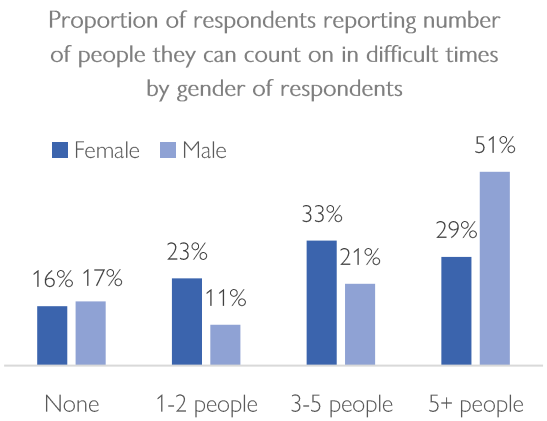


Figure 1b: Rohingya refugee community

The replies of the participants demonstrated strong social ties, with 42.95 per cent of the host and 36.54 per cent of the refugee respondents reported having more than five people they can count on in difficult times. It is worth noting that while there is no significant difference between host male and female participants, there is a difference between refugee male and female participants, with women reporting having fewer people they can count on.

2. How much interest and concern do people show in what you do?

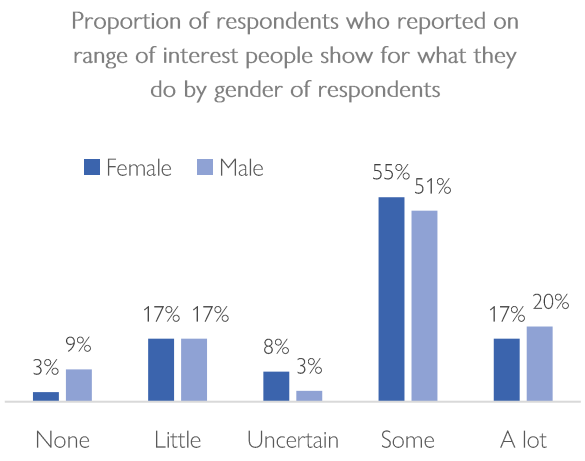


Figure 2a: Host community

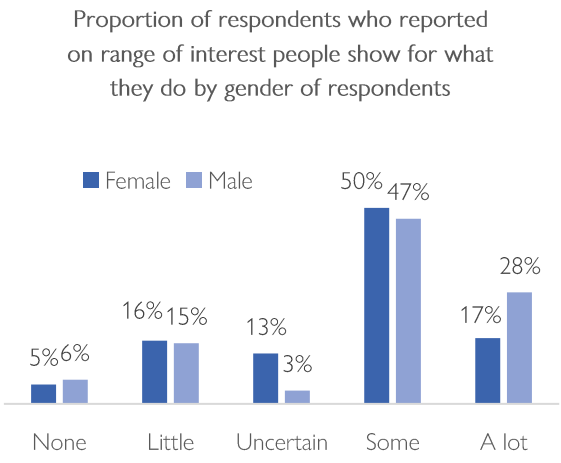


Figure 2b: Rohingya refugee community

A total of 53.93 per cent of the host and 48.69 per cent of the refugee respondents reported that other people show "some" interest in what they do. Only 17.98 per cent of the host and 20.79 per cent of the Rohingya participants reported "a lot", with a higher percentage of men in both groups. Women had a higher level of uncertainty to this question, in comparison to male participants.

3. How easy is it to get practical help from neighbours if you should need it?

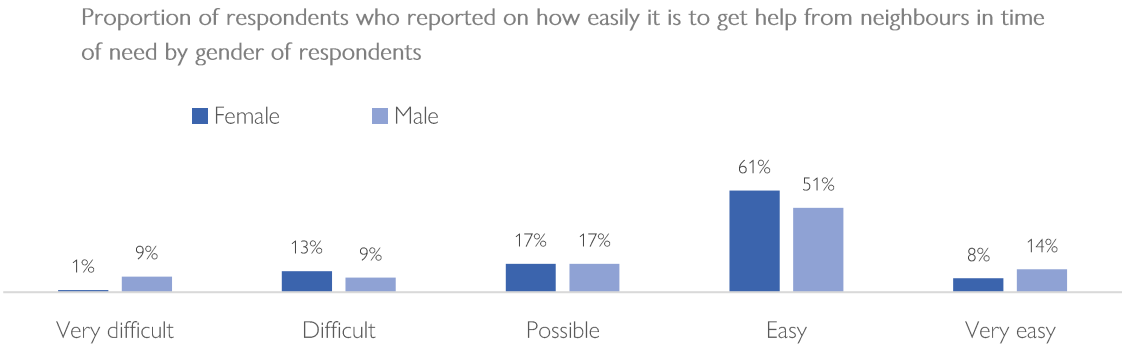


Figure 3a: Host community

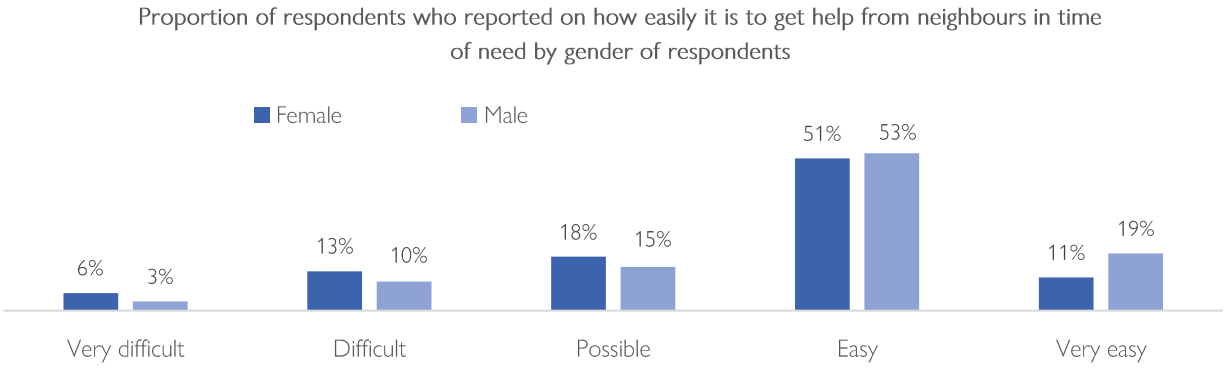


Figure 3b: Rohingya refugee community

The majority of both host (57.75%) and refugee (51.97%) participants said that it is easy getting help from neighbours in time of need, followed by "possible" (16.85% of host and 16.96% of refugee) and "very easy" (10.11% of host and 14.11% of refugee respondents). These results are indicative of the social support that prevails within the two communities.

Questionnaire – children

CPDS - THE CHILD PSYCHOSOCIAL DISTRESS SCREENER

1. Did anything bad happen to you or did you witness anything bad which made you unhappy?

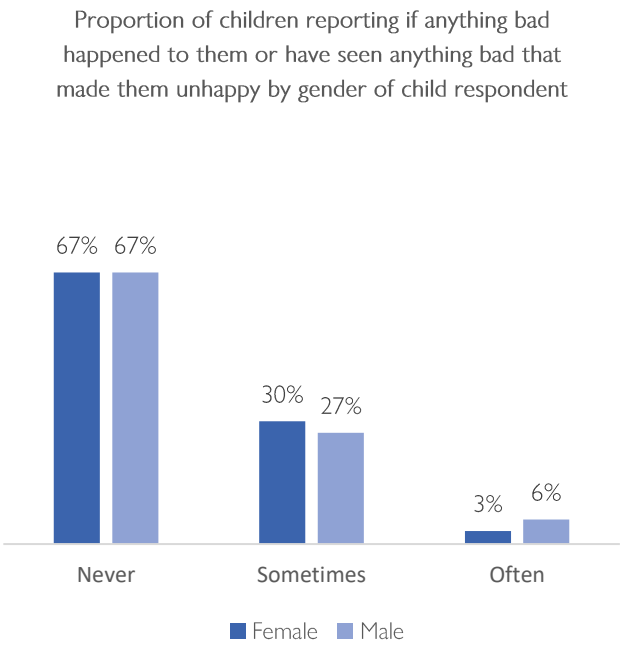


Figure 1a: Host community

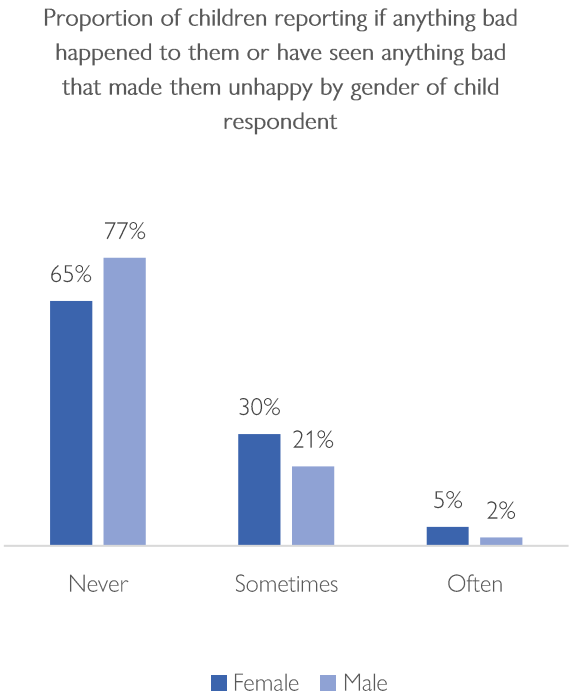


Figure 1b: Rohingya refugee community

Most of the children reported "never" (66.67% of host and 69.03% of refugee children) to the question on whether anything bad happened to them or if they witnessed anything bad which made them unhappy. "Sometimes" ranked second with 29.37 per cent of the host and 26.87 per cent of the refugee children choosing it. Only 3.97 per cent of host and 4.10 per cent of refugee children said "often".

2. Have you been worried by these events?

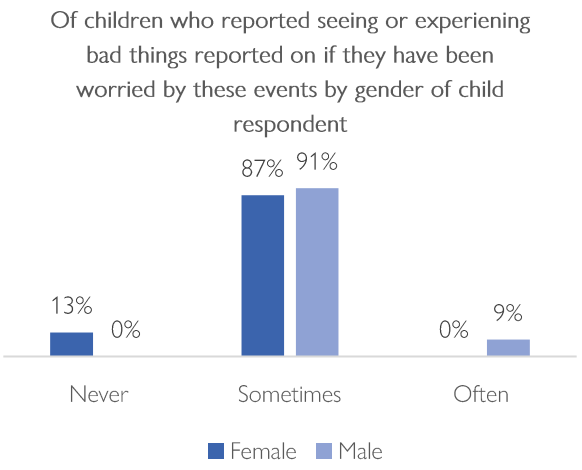


Figure 2a: Host community

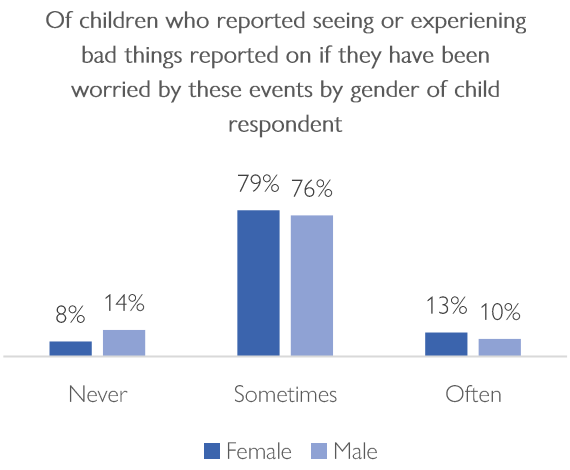


Figure 2b: Rohingya refugee community

During the interviews 88.10 per cent of the host and 78.31 per cent of the refugee children who reported experiencing or witnessing something bad to the previous question, said that they have been worried by these events "sometimes".

3. Are you distressed or experiencing problems?

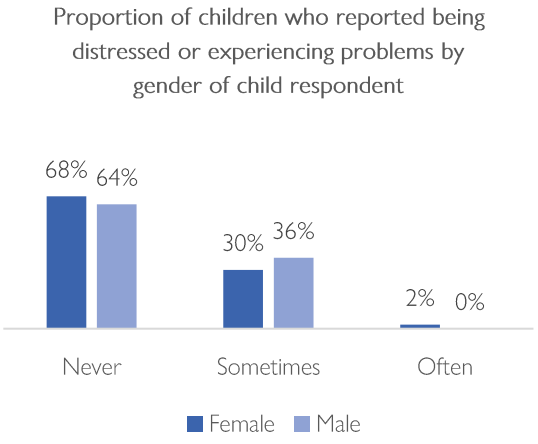


Figure 3a: Host community

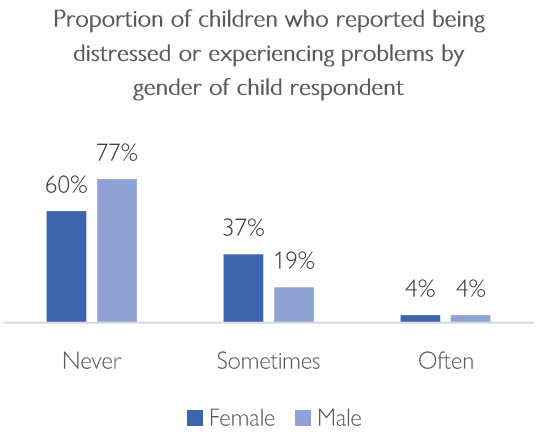


Figure 3b: Rohingya refugee community

Approximately 66.67 per cent of the host and 65.30 per cent of the refugee children reported never being distressed or experiencing problems, while 31.75 per cent (host) and 30.60 per cent (refugee) reported that they are "sometimes" distressed or experience problems.

4. Do you feel supported when you face some problems?

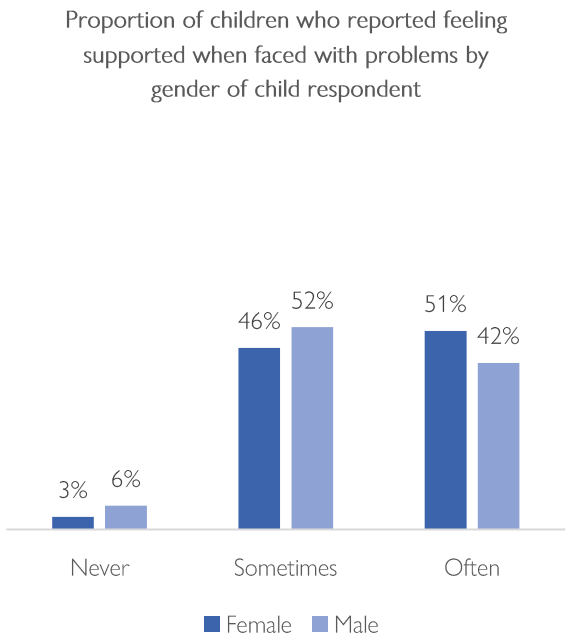


Figure 4a: Host community

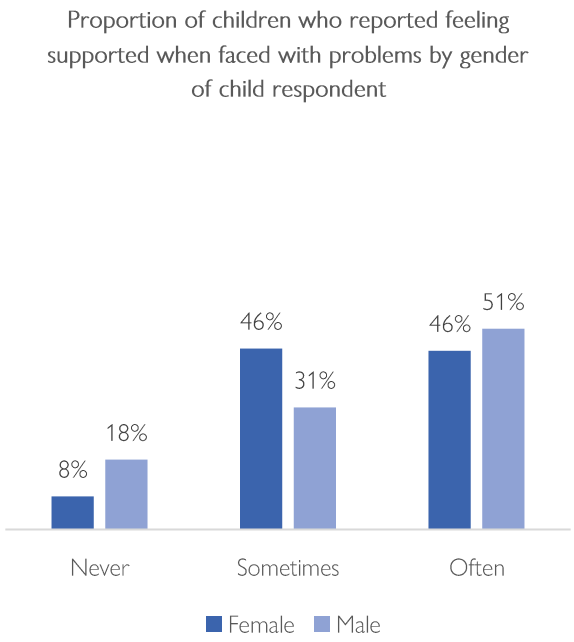


Figure 4b: Rohingya refugee community

Around 48 per cent of the host and 47.39 per cent of the refugee children reported that they often feel supported when they face some problems, followed by 47.62 per cent (host) and 41.04 per cent (refugee) who reported "sometimes". While most of the children respondents reported feeling supported "often" or "sometimes", we must highlight that their interview took place in the presence of their caregiver which might have influenced their choice.

5. How much do you feel able to deal with your problems yourself?

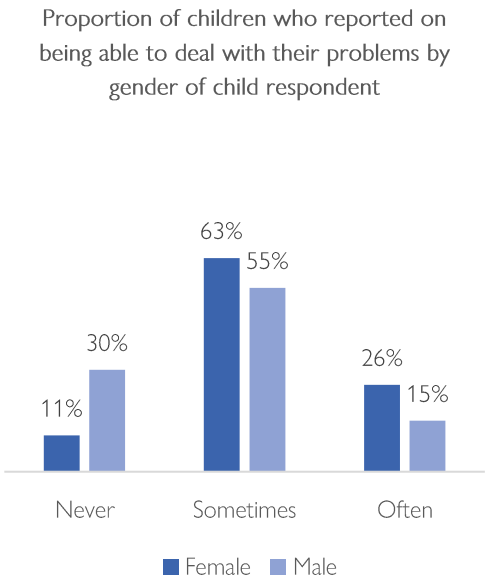


Figure 5a: Host community

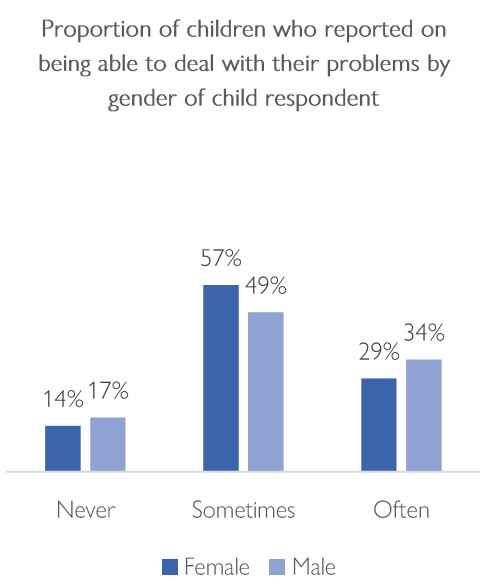


Figure 5b: Rohingya refugee community

Most of the children reported that they are "sometimes able to deal with their problems" (61.11% of host and 54.48% of refugee children), followed by those who reported "often" (23.02% of host and 30.60% of refugee children). Nonetheless, the percentage of children reporting that they "never feel able to deal with their problems themselves" is 15.87 per cent of the host and 14.93 per cent of the Rohingya children, with boys being the majority of both samples and host boys having the highest score of all four groups.

FINDINGS OF FOCUS GROUP DISCUSSIONS (FDGS)

The FGDs with the two communities gave a plethora of qualitative information and an insight into the community member's perceptions regarding stressors affecting their psychosocial well-being, coping mechanisms the communities adopted, knowledge on the availability of services as well as the type of support the participants consider appropriate to address their needs.

Sources of distress:

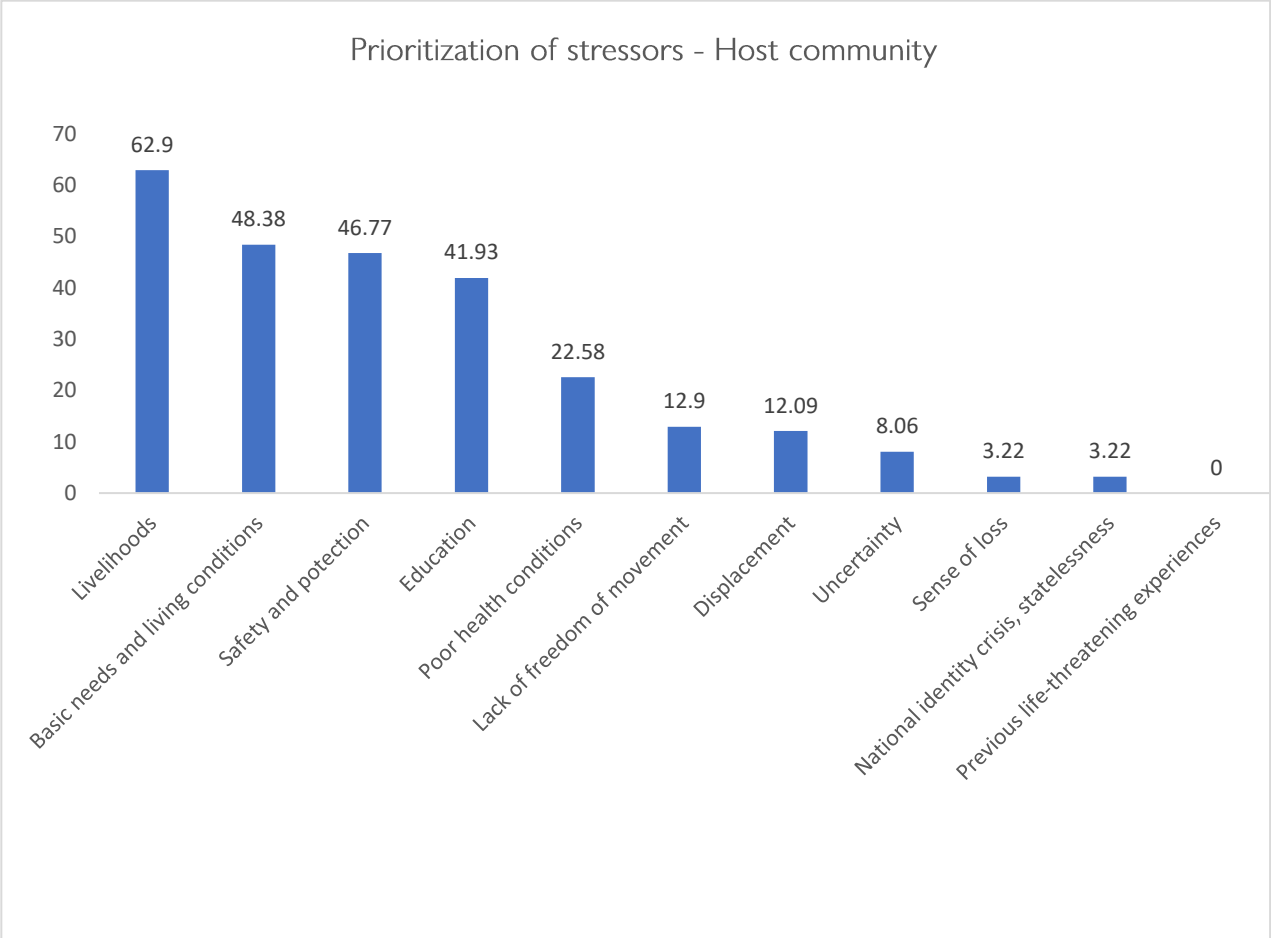
1. What kind of problems do you have (because of the humanitarian situation) that affect the way you feel? Please list as many problems that you can think of women, men, and children in your community face at the individual, family and community level.

During the free listing exercise, participants had the chance to discuss their problems further. Each group had to report the main challenges these three groups faced (men, women, and children) at the three levels (individual, family and community).

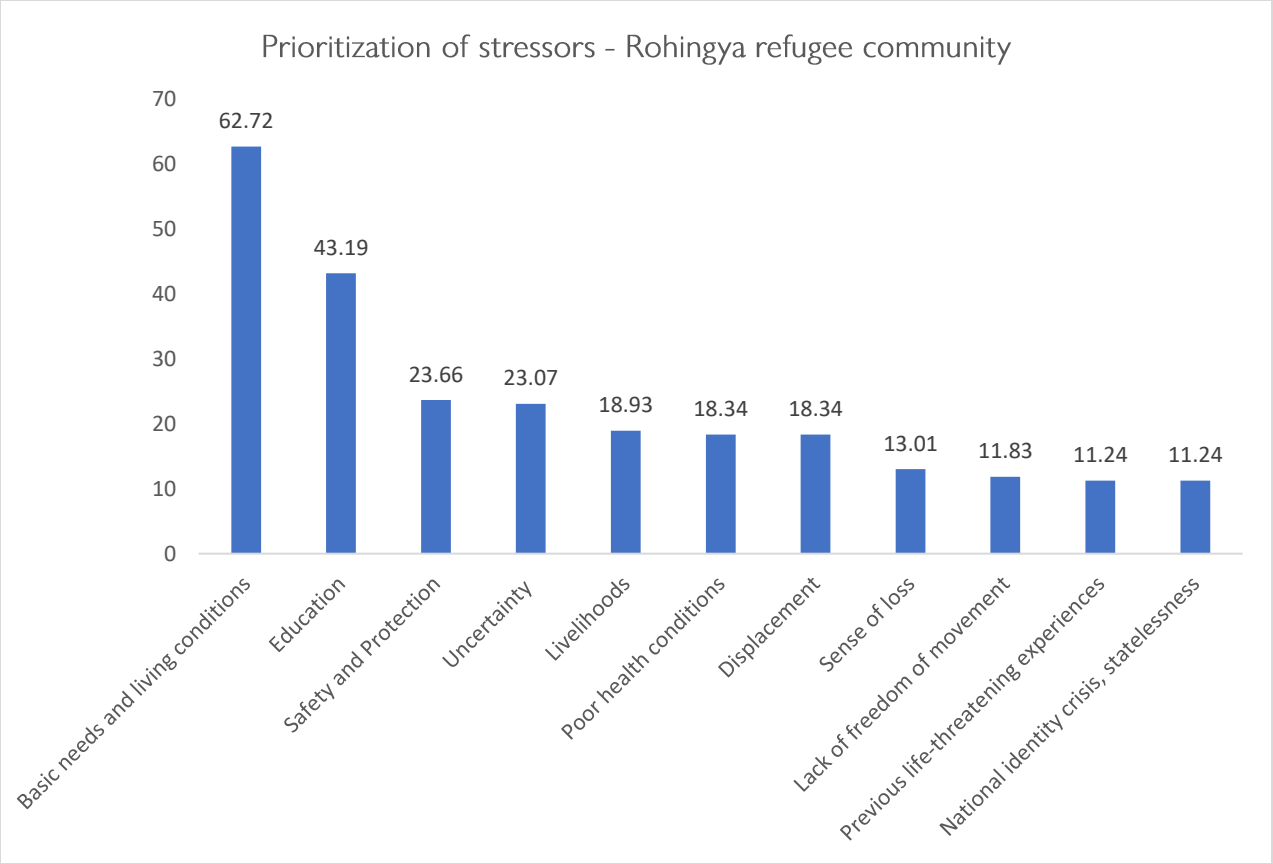
Rohingya refugees expressed the constant fear they experience about their safety. This fear stems from the incalculable adversities they had experienced and the previous life-threatening situations they had to go through in Myanmar. "*The violence we witnessed in Myanmar was unbearable, unimaginable. Whenever we think about it, we get sick*", shared an elderly woman in camp 13. After coming to Bangladesh in pursuit of safety, participants shared that they still face safety concerns, but these are now mostly related to the living conditions and the financial constraints that lead to protection concerns. For example, not having livelihoods opportunities renders them financially insecure and leads to child marriage and conflicts within the community. Being dependent on aid to fulfill the essential needs also creates insecurity. Men and women highlighted the heightened difficulties that female Rohingya refugees face due to the living conditions, such as lack of female exclusive latrines and adequate lighting in the camp. Many shared that the restriction of movement in Bangladesh reminded them of the situation in Myanmar. Among the discussed difficult living conditions, participants highlighted the fact that many refugees live in hilly areas, making access to services more challenging, while rendering them more vulnerable to natural disasters, such as cyclones. Most of the participants expressed their frustration due to gaps in essential services, such as receiving specific food rations regardless of the number of people each household accommodates, and lack of secondary and tertiary medical treatment. The sense of loss (of loved ones, property, land, previous life, purpose) was clearly expressed during most of the group discussions. In addition, Covid-19 generated more stress as the living conditions in the camps do not allow refugees to maintain physical distance and all the hygiene protocols.

The host community participants focused more on the living conditions, the fear of losing their land, the lack of livelihoods opportunities and on the dowry system. These problems have a cumulative impact and lead to family conflicts and competition between the two communities.

Prioritization of categories:



Participants from the host community prioritized the lack of livelihoods opportunities, unmet basic needs and living conditions and safety and protection concerns as the main stressors. Notably, they discussed concerns about the high rate of unemployment within their community, challenges they face with the cultivation of their land, how the Rohingya crisis impacted their lives, and other issues related to the living conditions, such as lack of clean water and appropriate road network.



Rohingya refugees prioritized the living conditions in the camps and unmet basic needs as the main stressor affecting their mental well-being, followed by the lack of formal education, safety and protection issues (such as harassment and child marriage), uncertainty about the future, lack of livelihoods opportunities, poor health conditions, displacement, sense of loss, lack of freedom to move, previous life-threatening experiences and national identity crisis / statelessness.

2. What do you think are the consequences of these problems on the emotional well-being?

	Individual	Family	Community
Answers given by the Host community	Increased stress, sleeping and appetite problems, tension, somatic problems, hopelessness, restlessness, suicidal thoughts, fear, sadness, anger.	Family conflicts, physical abuse of children, stress, weakened family relationships.	Early marriage due to instability and uncertainty for the future. Anxiety related to the loss of income, competition between the host and refugee communities.
Answers given by the Rohingya refugee community	Sadness, stress, grief, physical problems related to stress and other psychosomatic problems, worrying, anxiety, irritability, discomfort, lack of interest to work, lack of concentration, weight loss, tension, lack of emotional regulation, sleeping disturbances, impact on memory, anger, guilt, hopelessness, shame, depleted energy, restlessness, low self-esteem, lack of confidence, isolation, nightmares, , loss of hope, confusion. Children: discomfort, crying, sadness, irritability, aggressive behaviour, loss of appetite, loss of interest (even in playing), tension, anger.	Stress impacts the whole family and creates tension, worrying, becoming aggressive towards family members, stress and hopelessness related to the difficulty to provide for the basic needs, parental worrying related to children's malnutrition, weakened family bonding, difficulty to maintain balanced relationships, loss of pleasure within the family, loss of interest to work, uncertainty for the future, early marriage. Children: disobedience that creates conflict with the parents, withdrawal from the rest of family, sad to see their parents being helpless, feeling of being inferior due to the living conditions in the camps.	Anxiety related to lack of livelihoods, withdrawal from the community, conflicts, children cannot socialize due to the living conditions.

"Sudden noises trigger our fear that something bad is happening", shared an adolescent girl from the Balukhali host area, *"we just want to move to a place that is safe for everyone"*. Other host participants highlighted those parents were extremely stressed, which can lead to some types of violence, such as physical abuse.

Rohingya refugees stressed that the current situation generated feelings of anger but also hopelessness and unworthiness. *"Our brain is not functioning well, we don't understand the change of seasons anymore"*, shared a community leader in camp 9.

3. Which groups of the community are suffering the most? Why? (Who are the most vulnerable among youth, children, women, men and why?)

Host community: he host community prioritized women (as, according to them, they have a lot of burden on their shoulders and they are not as independent as they should be), older adults (and especially elderly women and those impacted by Covid-19), children (no space to play) and persons with specific needs, such as people with disabilities (the host participants mentioned that they face heightened challenges due to the lack of services tailored to their needs, such as accessible toilets).

Rohingya refugee community: According to the participants from the Rohingya refugee community, those suffering the most are:

- Women: divorced women and widows, female-headed families, women with no male guardian at home, pregnant women - especially those living in hilly areas (causing difficulty to collect food and water), and those suffering from domestic violence. The participants shared those women in camps face harassment, and the fact that they have less access to labour and therefore to financial means makes them more vulnerable. One of the Rohingya religious leaders in Camp 9 shared that "there are not enough safe spaces for women here, it looks more like a jail for them. Do you know how much women and girls are afraid when they have to use the toilet in the night?". People with disabilities and their caregivers who face significant barriers and need additional support.

- Young children: Malnourishment, lack of formal education, unhygienic environment, lack of safe spaces, dowry system and other protection issues have a cumulative impact on children's well-being. As an adolescent boy from camp 15 shared, "children suffer the most because they cannot express their suffering in words and be heard". The pandemic worsened the situation since learning centres and madrassas (Islamic religious schools) had to stop their activities. Furthermore, the economic hardship experienced by families led to an increase of child marriages. This strengthens the dowry system, which can motivate the groom's family (as they are entitled to ask for money, gold, or other material from the bride's family), but is a significant burden for the bride's family. In any case, members of the communities often believe that both families can benefit from these arrangements; the groom's family has an immediate financial benefit, while it is considered that the bride will be benefited in the long term, as her needs will be covered financially by the groom. These ideas contribute to the rise of the number of child marriages and have a toll on the mental well-being of both boys and girls.

- **Adolescent girls:** are considered to be a particularly vulnerable group due to the protection issues they face in the camps (such as lack of lighting and early marriage), the fact that they cannot seek medical treatment if they are unaccompanied, and the lack of education opportunities. A girl from the host community in Balukhali area shared, "Coming to this world as a girl is a bad luck; it is worthless. There is no freedom for girls, and we don't have access to all the benefits boys have".

- **People with chronic illnesses:** the unhygienic environment (poor drainage systems, inadequate sanitation, and piles of uncollected garbage) and the big gaps in specialized healthcare and the provision of specialized medication contribute to the worsening of the situation of this group.

- **Older adults:** those who are physically weak or ill, separated from their family and those who have fewer financial means. Participants shared that elderly woman are more vulnerable as it is difficult for them to perform daily tasks and collect humanitarian aid. People with severe mental health conditions due to their social isolation.

Psychological reactions and perceptions about mental health

4. How can a person recognize a person with severe mental health problems? How does s/he behave?

Host community: According to the host community respondents, persons with severe mental health problems:

- have a different physical appearance (dirty, not wearing proper clothes, awkward posture).
- uncomprehensive speech and use of inappropriate words.
- can be aggressive towards other people.
- don't take into consideration social norms and rules (eating from the garbage, remove their clothes in public, unpredictable behaviour).
- wander around without any purpose.

Rohingya refugee community:

- Communication: Are unable to explain their own needs, talk too much about irrelevant topics, can't understand what other people say, disorganized speech, self-talk.
- Appearance: dirty, not wearing proper clothes, nudity, lack of self-care, not having balance.
- Behaviour: restless, withdrawn and isolated from the community (sitting alone), no sense of social norms (e.g., eating garbage, don't know how to behave in public, "they do all the forbidden things" as a refugee woman in camp 3 said), demonstrate bizarre or aggressive behaviour (hurting others, throwing stones, shouting, chasing children), are disoriented and unpredictable, they wander in the streets, and are delusional.
- Participants added that people with severe mental health conditions have memory issues, dementia and epileptic seizures.

5. Coping strategies: What type of coping strategies persons with severe mental health problems use? To whom do they go for support and to seek help?

Host community: The participants shared that the family is the primary source of support for persons with severe mental health conditions. Other more popular practices include visiting a traditional healer and seeking medical support.

Rohingya refugee community: Based on what Rohingya refugees shared during the discussions, the most popular coping strategies are seeking support from family and neighbours, as well as from traditional healers ("boddho" in Rohingya language) and religious leaders. Others mentioned coping strategies including magic and sorcery practices, alternative treatments such as Ayurveda, and MHPSS services provided by humanitarian organizations. It is worth noting that people with severe mental health conditions often reach out to medical services for regular check-ups, as requesting for MHPSS support can be stigmatizing. It is particularly poignant that people with severe mental health conditions are often chained by their families, for fear of getting lost or creating problems with the neighbours. As it was shared by a group of elderly women in camp 13, caregivers of people with severe psychiatric conditions who need assistance for their daily functioning, often use shackling as a way to protect them in the congested camp areas.

6. How would any person recognize a person who is emotionally upset/ distressed? (but does not suffer from severe mental health condition). How does s/he behave?

Host community: Participants shared that people who are emotionally upset have different sleeping and eating patterns, they face concentration issues, cry a lot, cannot control their anger and have specific facial expressions that reveal sadness.

Rohingya refugee community: According to refugees, a person who is emotionally upset / in distress can be recognized by their facial expressions, lack of interaction with others (do not engage in conversations, stay silent, do not laugh), and are intentionally isolated from the rest of the community as they prefer to be alone. In addition, they cry a lot, fight with other people on small things, do not pray, forget easily, do not eat and constantly worry about everything.

7. Coping strategies: What type of coping strategies do these persons use? To whom do they go for support and to seek help?

Host community: People in distress turn towards religion. For example, they pray a lot and practice other religious activities.

Rohingya Refugee community: According to Rohingya participants, people who are emotionally upset engage in various religious activities, seek support from their family, community leaders, friends and neighbours and take the advice of people who are considered as wise within the community (like elderly respectable figures). Other coping strategies include spending time alone, spending time outside, socializing, seeking medical and MHPSS support, and call available hotlines.

8. What kind of things do people in your community do to deal with emotional problems? For example, things they do by themselves, things they can do with their families or things they do with their communities?

Host community: Participants prioritized engaging in activities with their loved ones or spending some time alone, opening up to family members and friends, sleeping, watching TV, reading, discussing with respectful members of the community, and seeking medical advice. Adolescents focused on spending time with peers and attending activities organized by humanitarian actors.

Rohingya refugee community: Rohingya refugees prioritized religious activities (for example. reciting the Quran) and discussions with religious (Imams) and community (Majhis) leaders. Elderly people (Murubbi) are always a reliable source of support for the community as well as family and friends. They also shared turning for support to humanitarian agencies for counselling or other recreational activities. Having privacy and being able to spend some peaceful time alone in the congested camps was also discussed by many participants as an efficient way to deal with emotional difficulties. Women refugees shared that sewing, embroidery, and spending time with other women in safe places are activities that help them feel better and ease their emotional discomfort.

COPING STRATEGIES AND RESILIENCE RESPONSES

9. Who have the most significant role to support the community?

Host community: Those who have the most significant role to support the host community seem to be religious and community (sorder) leaders, traditional healers, teachers, doctors and other educated persons, and local representatives of the government. Adolescent girls added that people from their community that are trained by NGOs can also play a significant role within their community.

Rohingya refugee community: According to the participants, religious leaders have the most significant role when it comes to providing support to the community, followed by community leaders, relief organizations, traditional healers, elderly people, teachers and others who have religious or formal education.

10. For people who are doing well, what personal, family and community traits make them to feel well? Please mention personal, family, and community traits.

	Individual	Family	Community
Answers given by the Host community	• Being able to maintain a good physical condition and practice self-care • Identify solutions to problems • Want to learn new things • Supportive • Positive • Love art	• Supportive families • Families that stay connected through difficult times • Open communication	• Offer support to peers / friends
Answers given by the Refugee community	• Social • Generosity • Be supportive • Share challenges with important others • Artistic skills • Like to learn new things • Calm • Control anger • Patience • Believing in God • Intelligent • Business skills • Demonstrate empathy	• Supportive families • Good communication with parents and siblings • Have income source • Share the sorrows	• Strong communities support each other • Elderly members share their wisdom • Engaging in activities together • Maintain community cohesiveness • Educated members of the community offer support • Sharing • Good communication skills • Sense of togetherness • Equality in terms of resources • Unity

11. What gives you hope?

Host community:

- Faith ("only Allah can help us to overcome the problems we face" shared a woman in Baharchoara area)
- Family
- Humanitarian aid support
- Supporting each other
- Having the opportunity to study
- Accessing basic needs would give us hope to continue living

Rohingya refugee community:

- Faith
- Community support
- Hope of repatriation and freedom of movement ("We live for the day we will be able to go back to our homeland", shared a young man in camp 2W. "Now we only have one hope, to go back to our homes", said a religious leader in camp 9).
- The possibility of children to have access to education
- Seeing elderly people of the community being happy
- Attending community events and engage in activities
- Having someone listening to them
- Having the basic needs covered (such as having enough food)
- Having education opportunities
- Playing and having safe spaces to spend time with friends
- Spending quality time with family
- Reunion with friends and family
- Having livelihoods opportunities
- Get support from neighbours
- Receive proper medical support
- When media share positive news for Rohingyas.

12. Do you have some traditional rituals to deal with emotional difficulties? Please list them and the description of those.

Host community:

- Rituals suggested by traditional healers
- Religious rituals suggested by "Mosque Imam", such as applying holy oil on their skin, drink holy water and wear specific religious clothes
- Organizing community events with music

Rohingya refugee community:

- Attending religious healing ceremonies ("Talim", "Doa Mahfil"/ "Fatiha") and activities, like communal / collective prayers, drinking holy water
- Storytelling activities where elders share traditional stories
- Meetings with the community to discuss common problems
- Spiritual ceremonies organized by traditional healers (like sacrificing chickens to save someone's life or scratching the back of someone with chicken legs to send the jinni[3] away)

13. What is the ritual that could strengthen your resilience as a group/ community?

Host community: Participants shared that spiritual and religious ceremonies can strengthen the resilience of the community.

Rohingya refugee community: Celebrating religious festivities together (Eid-ul-Azha, Eid-ul-Fitr), organizing marriage ceremonies, attending recreational activities, and reunite with loved ones. Rohingya participants shared those picnics ("poa vat") were very popular in Myanmar and it was a great opportunity for the community to come together to cook, spend time together and celebrate.

[3] A jinni is believed to be a supernatural spirit that can induce mental health and physical related conditions in people. These creatures can manifest themselves to humans in different forms, such as animals or fire, and have the power to make people behave in a way that is not socially accepted.

Information on available support and perception of appropriate support

14. Can you provide information on the existing services that are currently available to respond to your personal or family uneasiness? (This can include medical services, legal counselling, traditional healing and informal community help).

Host community: The host community mentioned medical services / hospitals in their areas, and local government services. They added traditional healers and Imams to the list.

Rohingya refugee community: Refugee participants mentioned MHPSS services of humanitarian actors, medical services, community leaders, traditional healers, humanitarian aid organizations (and listed the services of each organization), and CiCs (Camp in Charge[4]). An important portion of participants replied that they don't know the available services.

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[4] The governmental coordination unit in the refugee camps of Cox's Bazar

15. Are there any obstacles in place to access these services (both formal and informal)?

Host community: The main mentioned obstacles were financial problems, transportation issues, long distance and misbehaviours of some medical staff, such as rude behaviour, disrespect, and lack of information sharing. A significant percentage of participants mentioned that relief organizations give the priority to Rohingya refugees and the host community feels neglected.

Rohingya refugee community: Rohingya refugees mentioned several obstacles:

- Those who don't have children have less access to services
- Households with no male persons have less access, as women must be accompanied by men and men have more information regarding available services
- Those living on hills have to walk long distances
- People don't always have the information on the available services, limited knowledge about services
- Single women cannot go to services by themselves
- Don't have available clothes to go out of the house
- Language barriers
- Fear of rejection
- Time consuming service provision
- Possibility of disrespect
- Delayed or inappropriate care

16. If yes, what is your suggestion to overcome them?

Host community:

- Provision of free treatment
- Availability of ambulance support and provision of transportation
- Be treated with respect regardless of their financial situation
- Decrease discrimination between host and refugee communities

Rohingya refugee community:

- Home visits or spaces only for women to receive treatment / services
- Respectful service providers
- Reducing the waiting time
- Actors to provide information about the existing services
- Availability of translation from Bangla to Rohingya language and vice versa.

17. In your opinion, which are the actions that could be taken in order to improve the overall mental well-being of your community?

Host community: having more mosques and praying areas, having more schools and adolescent clubs within the community are some of the actions suggested by the participants that could contribute to improve the overall well-being of the host community.

Rohingya refugee community: the refugee community gave the below suggestions:

- Ensure the safe repatriation of Rohingya refugees. "We want to go back to our homes and live peacefully together"
- Ensure that all the basic needs of refugees are met, including medical support and access to formal education. "Peace of mind is found when the needs are met", stated a male Rohingya refugee in camp 9
- Creating more places to pray
- Organize community events in the camps to increase social bonds
- Improve the living conditions of refugees that impact heavily their mental well-being
- Ensure freedom of movement
- Creating opportunities to solve conflicts and reduce family and community tension
- Having more safe spaces and playgrounds for children and adolescents
- Fighting the early marriage phenomenon and establishing laws to prohibit dowry

18. Can you suggest anything you will personally find useful?

The host community requested more recreational activities, especially for women.

Rohingya refugees suggested having more group sessions where they can discuss the common challenges, improve living conditions (such as waste management), having more recreational activities, involve religious leaders in awareness-raising activities, having more Women Friendly Spaces (WFS) as well as safe spaces for men, more child-friendly activities.

LIMITATIONS

Given that the report methodology was based on random sampling, the results can be considered as statistically representative and indicative of the assessed population. However, this result does not represent the entire host and refugee population of Cox's Bazar district.

The main study limitations were:

- Timing of the assessment. The period of data collection was marked by considerable concerns of the refugee community regarding relocation to *Bhasan Char* island. This situation generated generalized fear and mistrust towards actors present in the camps and therefore, affected the process of obtaining consent from the refugee participants for their participation in the survey, to some extent.

- Confidentiality. Preserving confidentiality was in some cases challenging, especially during the interviews in households, as the participants were often interviewed in the presence of other family members. In addition, in some cases gatherings were inevitable as the majority of the respondents live in very congested areas, especially those living in the refugee camps.

- The scales that were used for this assessment did not go through full validation procedure for these populations due to the time constrains. However, IOM tried to mitigate this limitation by organizing several validation FGDs and piloting the assessment methods.

- Availability of participants. Given that men are traditionally the breadwinners of the families, it was more challenging to identify male participants for the quantitative part of the survey, and therefore the percentage of women participants was higher.

- Covid-19 affected the whole process, posing challenges in terms of the mobility of the teams, interaction with survey participants, and organization of FGDs.

- Translation. Even though the tools were translated, and the translated versions have undergone verification for the FGDs, inconsistent interpretation during field roll out can result in bias during the data collection and analysis.

- Social influence. During the FGDs participants had to share their views in front of a group, increasing the possibility for biased results.

- Social desirability bias is expected to interfere with the results of every survey, as it is proven that participants can be driven by an unconscious desire to provide a reply that will meet the expectations of the interviewer.

- It was challenging extracting information from the FGDs with adolescent girls from both communities due to cultural limitations.

- No group of host adolescent boys participated in the main FGD activity due to the limited time of the assessment exercise. An initial FGD with host adolescent boys was conducted in Balukhali host area during the validation phase of the assessment tool and their perceptions, concerns and resilience responses were noted by the team.

- Concepts and understanding of MHPSS issues varied between the two communities. Rohingya refugees seem to be more familiarized with MHPSS services and concepts, as there are more MHPSS actors present in the camps than in the host community. Moreover, more awareness-raising sessions related to mental health have been conducted for the Rohingya community.

- Among some important events that might have impacted the psychosocial well-being of the assessed population was a fire incident in March 2021 that affected three Rohingya refugee camps and the host areas around these camps, and an imposed Covid-19 related lockdown in April and May 2021. This survey does not include any information on these issues and how they have impacted the refugee and host communities.

- General limitations of checklists that can potentially affect qualitative information, such as not taking into consideration environmental factors.

SUMMARY OF RESULTS

Despite the limitations, the assessment reveals notable findings that provide key insights into the host and Rohingya refugee populations' needs. These findings allow for gaining a better understanding of the communities' perceptions regarding stressors, signs of distress, coping mechanisms, protective factors and culturally appropriate support and could provide guidance in the design and implementation of future MHPSS activities.

General observations:

In general, the data demonstrate a high level of mental health and psychosocial difficulties that both communities face. At the same time, the host community's challenges are often overlooked by stakeholders. Both populations seem to be affected by several factors impacting their mental health and psychosocial well-being, such as the lack of educational and livelihoods opportunities, the non-fulfillment of basic needs and the dire living conditions, and safety and protection issues.

Overall, the Rohingya refugee community was more familiar with the assessment process and could share more detailed information than host community participants. For many women and adolescent girls, this was the first time they participated in such as assessment.

KEY FINDINGS

1. Stressors

For the host community participants, the main stressors were (the lack of) livelihoods (62.9%), basic needs and living conditions (48.38%), safety and protection (46.77%), education (41.93%), poor health conditions (22.58%), lack of freedom of movement (12.09%, related to the imposed Covid-19 lockdowns that hampered movement, displacement that was caused by the refugee influx and the creation of big refugee camps in areas that were previously parts of the host community), and displacement (12.09%). For the Rohingya refugee participants, the main identified stressors were basic needs and living conditions (62.72%), education (43.19%), safety and protection (23.66%), uncertainty (23.07%), livelihoods (18.93%), poor health conditions (18.34%), displacement (18.34%), sense of loss (13.01%), lack of freedom of movement (11.83%), previous life-threatening experiences (11.24%), national identity crisis or statelessness (11.24%).

Though it was not specifically investigated by this assessment, we can assume that Covid-19 impacted both communities, especially in terms of people's financial situation and the disruption of formal and informal education. In addition, the status of FDMN (Forcibly Displaced Myanmar National) as well as the status and experiences Rohingya had in Myanmar influence the stressors affecting their well-being (lack of education, uncertainty, displacement, sense of loss, previous life-threatening experiences, national identity crisis or statelessness).

2. Mental health and psychosocial difficulties:

Symptoms: The findings of the questionnaire confirm that a big part of the population experiences symptoms suggestive of depression, anxiety and stress.

The mental health and psychosocial difficulties the host community reported experiencing are summarized in the table below, based on the frequency:

MHPSS difficulties	Experienced this difficulty for at least 8 in 14 days	Experienced this difficulty nearly every day (13-14 days)	Significant variances
Feeling tired or having little energy	39.33%	14.61%	
Little interest or pleasure in doing things	38.68%	16.85%	Host men are more likely to report "every day" (23.91% men vs 13.68% women)
Feeling tension or nervousness	37.30%	13.93%	
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	30.78%	9.21%	Men were more likely than women to report feeling bad about themselves 8-14 days (39.86% men vs 26.71% women)
Feeling down, depressed or hopeless	26.96%	10.56%	
Trouble falling or staying asleep or sleeping too much	25.17%	9.21%	Women in both groups reported facing more troubles related to sleeping patterns between 8 and 14 days (26% women vs 23% men of the host community and 29% women vs 23% men of the refugee group)

Feeling afraid as if something awful might happen	23.15%	8.09%	
In the last 2 weeks, how often have you felt you had so many difficulties that you could not overcome them?	20.09%	4.27%	Men report more frequently than women feeling that they could not overcome their difficulties for at least 8 in 14 days (26% men vs 19% women from the host and 25% men vs 18% women from the refugee community)
In the last 2 weeks, how often have you felt that you were unable to control the important things in your life?	22.02%	3.37%	Men were more likely than women to report feeling unable to control the important things in their lives for at least 8 in 14 days (30% men vs 18% host women and 25% men vs 18% refugee women)
Becoming easily annoyed or irritable	19.11%	3.60%	
Poor appetite or overeating	17.76%	6.07%	
Trouble concentrating on things, such as reading (like the Quran or any other religious book), reciting Quran (if relevant), sewing, doing calculations	17.53%	4.27%	
Being so restless that it's hard to sit still	16.84%	4.93%	
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so restless	15.28%	3.82%	

that you have been moving around a lot more than usual			
Not being able to control worrying	14.61%	3.82%	
Thinking too much about bad things	13.93%	4.04%	
Trouble relaxing	13.26%	3.15%	
Thoughts that you don't want to continue living	12.13%	3.82%	46.96 per cent of the host participants reported having these thoughts for at least 1 in 14 days

The MHPSS difficulties the refugee community reported experiencing is summarized on the table below, based on the frequency:

MHPSS difficulties	Experienced this difficulty for at least 8 in 14 days	Experienced this difficulty nearly every day (13-14 days)	Significant variances
Feeling tension or nervousness	37.86%	18.60%	
Feeling tired or having little energy	34.58%	15.43%	Men from the host community reported feeling tired or having little energy almost every day at 17 per cent while refugee men reported the same at 16 per cent, refugee women at 15 per cent and host women at 13 per cent

Little interest or pleasure in doing things	31.51%	18.82%	Men report having little interest or pleasure more frequently more than women (26.07% vs 14.80%)
Feeling down, depressed or hopeless	29.65%	15.97%	
Feeling afraid as if something awful might happen	27.68%	14.77%	
Trouble falling or staying asleep or sleeping too much	27.13%	12.47%	
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	23.42%	11.49%	Men were more likely than women to report feeling bad about themselves 8-14 days (33.74% men vs 17.68% women)
Poor appetite or overeating	21.99%	8.86%	
In the last 2 weeks, how often have you felt you had so many difficulties that you could not overcome them?	20.14%	8.10%	Men reported more frequently feeling not able to overcome their difficulties on 8-14 days (25.15% men vs 17.34% women)
Thinking too much about bad things	20.13%	9.41%	
In the last 2 weeks, how often have you felt that you were unable to control the important things in your life?	19.14%	6.67%	Men report more than women feeling unable to control the important things in their life (23.07% men vs 17.01% women)
Trouble concentrating on things, such as reading (like the Quran or any other religious book), reciting	17.94%	6.89%	

Quran (if relevant), sewing, doing calculations			
Not being able to control worrying	16.53%	6.35%	
Being so restless that it's hard to sit still	16.19%	5.80%	
Becoming easily annoyed or irritable	12.91%	3.61%	
Trouble relaxing	12.69%	5.47%	
Thoughts that you don't want to continue living	12.48%	4.38%	44.54 per cent of the refugee participants reported having these thoughts for at least 1 in 14 days
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so restless that you have been moving around a lot more than usual	12.26%	4.05%	

The results demonstrate that both communities experience psychosocial difficulties with some minor differences between the two. The five main mental health and psychosocial difficulties experienced for more than half of the days in two weeks by the participants of the host community are "feeling tired or having little energy" (39.33%), "little interest or pleasure in doing things" (38.68%), "feeling tension or nervousness" (37.30%), "feeling bad about myself – or that I am a failure or have let myself or my family down" (30.78%), and "feeling down, depressed or hopeless" (26.96%). The five main MHPSS difficulties experienced for more than half of the days in two weeks by the participants of the Rohingya community are "feeling tension or nervousness" (37.86%), "feeling tired or having little energy" (34.58%), "little interest or pleasure in doing things" (31.51%), "feeling down, depressed or hopeless" (29.65%), "feeling afraid as if something awful might happen" (27.68%). Women from both communities reported more frequently "feeling tired or having little energy" between one and 14 days (85% host women vs. 74% host men and 79% Rohingya women vs. 66% Rohingya men. This could be related to the workload of household, their traditional role as caregivers (of children, elderly, people with disabilities, etc.) and the multiple barriers they face in their daily life, such as collecting humanitarian aid. Men from both communities were more likely to report experiencing more frequently some mental health and psychosocial difficulties for at least eight in fourteen days, such as "having little interest or pleasure" and "Feeling bad about myself - or that I am a failure or have let myself or my family down".

The percentage of participants who reported having thoughts of not wanting to continue living is very concerning. 12.13 per cent of the host community members reported having these thoughts for at least eight in fourteen days, while 3.82 per cent reported having these thoughts nearly every day. A total of 46.96 per cent of the participants had these thoughts at least once in fourteen days. "*I just want to go into the ocean and never come back again*", a man from the host community in Shamlapur shared during the FGD. Roughly 12.48 per cent of Rohingya refugees reported having these thoughts for at least eight in fourteen days, 4.38 per cent nearly every day and 44.54 per cent for at least once in fourteen days.

The qualitative information that was collected during the FGDs confirms the findings and sheds additional light regarding the consequences of stressors on the emotional well-being of the participants. Apart from the above-mentioned difficulties, the participants shared that they experience psychosomatic problems, hopelessness, fear, sadness, anger, low self-esteem, and confusion. In addition, the identified stressors have an impact on families and communities. Family conflicts, domestic abuse, and weakened family relationships were reported by both groups. Regarding the impact on communities, the main identified difficulties were early marriage (due to instability and uncertainty for the future), withdrawal, and competition between the host and refugee communities.

Both groups identified women, adolescent girls, older adults, children and persons with specific needs, such as people with disabilities, as the most vulnerable groups in need of support.

Mental health and psychosocial difficulties of children

Most of the children (66.67% host and 69.03% refugee) reported that they "never" experienced or witnessed something bad which made them unhappy. Only 29.37 per cent of the host and 26.87 per cent of the children from the refugee communities reported "sometimes" and 3.97 per cent of the host and 4.10 per cent of the refugee children reported "often". Those who have experienced or witnessed something bad reported that they are "sometimes" worried by these events (88.10% of the host and 78.31% of the refugee community). When child respondents were asked if they are distressed or experiencing problems, most of them replied "never" (66.67% host and 65.30% refugee), with a smaller percentage replying "sometimes" (31.75% host and 30.60% refugee) and a small percentage replying "often" (1.59% host and 4.10% refugee). 76.67 per cent of Rohingya boys replied "never", which can be related to gender expectations within their community and not to reality.

In terms of support ("do you feel supported when you face some problems"), 48.41 per cent of the host and 47.39 per cent of the refugee participants replied "often", while the percentage of the sample replying "sometimes" was at 47.62 per cent for the host and 41.04 per cent for the refugee children. The percentage of Rohingya children (11.57%) replying "never" was higher than for the host children (3.97%). This could suggest that Rohingya children feel less supported by their environment.

Regarding the responses about resilience, most of the children replied that they sometimes feel able to deal with their problems themselves (61.11% host and 54.48% refugee children), followed by those who replied "often" (23.02% of the host and 30.60% of the refugee sample). The percentage of children who replied

"never" is not negligible; 15.87 per cent of the host and 14.93 per cent of the refugee children stated that they never feel able to deal with their problems without any support. Nonetheless, the percentage of children reporting that they "never feel able to deal with their problems themselves" is 15.87 per cent of the host and 14.93 per cent of the Rohingya children, with boys being the majority of both samples and host boys having the highest score of all 4 groups (30%)

It is important to note that the interviews of children took place in the presence of caregivers and therefore, their replies might have been influenced as the confidentiality was compromised.

3. Coping mechanisms, resilience factors and support

The majority of both communities reported that they tend to continue their life quickly after hard times at 56.18 per cent of the host and 55.03 per cent of the refugee respondents (Agree + Strongly agree), with men from the host community scoring the highest percentage (15.22% of host men strongly agreed with the statement). Interestingly, the majority also reported having a hard time making it through stressful events (64.05% of the host and 72.13% of the refugee respondents). Host men scored again the highest percentage (18.21% strongly agreed), while host women disagreed at 18.24 per cent. These two findings are contradictory; a possible explanation could be that the participants bounce back after difficult times, despite the incalculable challenges they face.

Most of the participants reported having more than three people that they can count on (75.73% of the host and 65.31% of the Rohingya group), while 42.92 per cent host and 36.54 per cent of Rohingya reported having more than 5 people. Rohingya men reported having more than 5 close people at 50.92 per cent. A possible explanation is that men can move in the camps more freely and therefore have more social interactions. However, the percentage of people reporting having none is important: 11.01 per cent of the host and 16.08 per cent of the refugee participants, indicating that a significant percentage does not have any social support to rely on.

Neighbours are a source of support for the majority of the participants, with 67.86 per cent of the host and 66.08 per cent of the refugee participants reporting that it is easy to get practical help from them. Nonetheless, the percentage of Rohingya refugees reporting that it is difficult to get help from neighbours is at 16.96 per cent, demonstrating that an important percentage feel isolated from their community.

Based on the qualitative data from the FGDs, the primary source of support for both groups is family, followed by religious leaders. Traditional healers tend to be an important source of support while Rohingya are more eager to seek support from MHPSS services (host community referred to "medical" services). This might be based on the fact that more MHPSS services are available for the Rohingya than for the host community and their access to them is easier.

Religion plays a primordial role in healing for host and refugee participants as both stated that they tend to engage with religious activities as a coping mechanism. Religious leaders, along with community leaders, the

elderly and other respectable figures such as doctors, teachers and traditional healers have the most significant role in terms of supporting the community. It is important to note that only Rohingya participants included humanitarian actors in the sources of support. One potential explanation for this could be the limited provision of humanitarian support for the host community, which makes host community less familiarized with this type of services. In addition, adolescents prioritized peer support and women shared that spending time in safe spaces is an important source of well-being for them.

4. Perceptions about people with mental health conditions

The perceptions of people suffering from mental health conditions are mostly based on stereotypes, with both communities stating that bad physical appearance, lack of communication, aggressive behaviour, withdrawal from the community and disrespect of the social norms are the main indicators of mental health suffering.

5. Information on available MHPSS support and perception of appropriate support

The host community seemed to be more familiar with medical services and government services but less with humanitarian aid, while the Rohingya refugee community seemed to be more oriented and have more information, as they listed several MHPSS services available in the camps. Yet, a big part of the participants did not have any information, indicating a big gap in information sharing.

The identified obstacles accessing MHPSS and other services were different for the two communities. Host participants mainly mentioned financial constraints and transportation issues. Additionally, during the FGDs, it was frequently shared that the host community feels neglected by humanitarian aid agencies, a feeling that widens the gap between the two communities and increases community adversity. Rohingya participants mentioned that women face multiple barriers accessing the services, especially those who don't have male family members living with them and added limited information, language barriers and services that do not necessarily correspond to their needs to the factors hampering their access to services. Distance and behaviour of service providers were determinants for the access of services for both communities.

The practice of shackling (shackling people with mental disorders to limit their movements) was also discussed during the FGDs. The participants shared that this is an ultimate solution as they don't seem to have any other alternatives, such as inpatient care for psychiatric patients.

When respondents were asked to suggest appropriate ways of support for their mental well-being, the host community referred to religious activities, safe spaces for all and adolescent clubs. Rohingya participants added community and family events to enhance social cohesiveness, recreational activities for children and adolescents and advocacy for their rights, including repatriation to Myanmar. All the participants agreed that educational

opportunities also improve the psychosocial well-being of the communities. Most of the suggested activities are community-based, which is proof that this type of activities is well accepted by the communities and considered as effective.

One additional barrier to access to MHPSS services for both communities (though it was not discussed during the FGDs) was the Covid-19 lockdown and the increased restriction of movements. Most PSS actors operate under the umbrella of Protection units and did not have access to the field during the several strict lockdowns that were imposed by the government of Bangladesh in 2020 and 2021. Only limited MHPSS actors who operate under Health units could join the refugee camps and host communities (including IOM MHPSS team). Therefore, the availability of MHPSS services was significantly decreased during this period.

RECOMMENDATIONS

Some recommendations for future programming and MHPSS interventions based on the findings are:

- Differences between host and refugee communities are to be taken into consideration in programme design to ensure that the suggested activities are tailored to the needs of each community.

- Activities that promote community cohesion should be prioritized, as both communities rely on their social environment for support. Some examples of these activities include socio-relational activities, spiritual ceremonies and family dialogues that build on the resilience of the communities and help them to deal with emotional difficulties.

- Building the capacity of the community is essential for future activities. Strengthening the community by encouraging community-led activities will deepen community engagement while ensuring the provision of culturally sensitive assistance. Community members also function as gatekeepers and significantly increase the access of humanitarian actors to the communities. For example, religious and community leaders and other persons that are respected and influential should be involved in awareness-raising campaigns and other MHPSS group activities. In addition, community people can be an important part of referral mechanisms. Organizations should provide support and guidance to community members to ensure the quality in the provision of services of community - driven MHPSS activities.

- Actors should design multi-layered holistic programmes, based on IASC recommendations and ensure the accessibility of services to everyone. According to the IASC multi-layered approach, all involved actors should "advocate for basic services that are safe, socially appropriate and protect the dignity of affected by crisis populations" (IASC guidelines). Furthermore, it is widely acknowledged that most people recover from adversities if they have access to family and community support systems. These social systems contribute to the maintenance of the mental well-being of everyone and can alleviate further exacerbation of mental and psychosocial problems. It is therefore proposed that these layers are prioritized in all MHPSS programmes while focusing only on the individual level should be avoided.

- A big gap in services for people with severe mental health conditions was identified by the assessment. Currently, there are only three available psychiatrists for two communities and there is no provision of hospitalization. This gap undeniably affects the quality of life of this group of population and their caregivers. It is recommended bridging this resource gap and adopt a more systemic approach in the provision of psychiatric support to offer quality services and avoid detrimental for the mental well-being practices, such as shackling.

- Participants in the FGDs raised the concern that they face language barriers in the provision of services as well as other cultural obstacles. All service providers are encouraged to deliver culturally informed services in a way that is appropriate for all the users of the services. Subsequently, actors should take into consideration translation issues and ensure that all staff has a good understanding of the concept of

culturally appropriate mental health and psychosocial support for both the Rohingya refugee and the host communities.

- A considerable percentage of the FGD participants from the host community did not have information on the available services. This can be attributed to many reasons, mostly on the limited dissemination of information and outreach in their areas and on the fact that the mapping of services in host areas is more challenging, as services can be scattered. This issue can be addressed by increasing awareness-raising sessions for the host community and ensuring that both communities have access to the information on available services (e.g., by conducting home visits, engaging community leaders in the dissemination of information, and disseminating information in an inclusive way that can be understood by everyone). Furthermore, and despite the fact that Rohingya refugees seem to have more information regarding the services, "Rohingya refugees tend not to seek formal help for mental health problems, which may be partly related to the limited familiarity with concepts around mental health and formal mental health care and to the belief that mental health conditions are a sign of weakness and something to be ashamed about. Only when a problem is perceived as physical in origin will medical care be sought" (UNHCR, 2018). For this reason, additional awareness raising sessions could facilitate their access to services while reducing the stigma related to mental health conditions.

- Ensure synergies between sectors and reinforce an MHPSS approach in the provision of all services. Mainstreaming MHPSS consideration in other services can increase the provision of services in a way that respects the dignity of service users and reinforces the transparency of service providers.

- Integration of MHPSS services to primary healthcare is essential, as medical services are often the first point of entry of service users. The integration also reduces barriers related to stigma and misinformation. According to the FGD findings, a lot of people of concern visit health facilities and seek medical support when they experience symptoms related to mental health. The integration of MHPSS services into primary healthcare strengthens the referral pathways and supports the provision of holistic care.

- Integration of MHPSS and protection services is important. Protection concerns have an impact on the mental and psychosocial well-being of people of concern and vice versa. Participants from both communities expressed their deep concerns about protection issues, such as child marriage, dowry system and domestic violence, that have a direct impact on their well-being. MHPSS and Protection actors should synergize the efforts to address several concerns in a holistic manner.

- As the lack of education opportunities was one of the main stressors impacting negatively the mental and psychosocial well-being of both communities, MHPSS and education sectors are recommended to work more closely and foster partnerships.

- According to the FGD findings, the majority of respondents seek initially support from their community whenever they face challenges, such as Imams and traditional healers. Capacity building of all first responders is essential for the early detection of psychosocial challenges and the establishment of an efficient referral pathway. People from the community should be included among the first responders (for

example. MHPSS volunteers, community and religious leaders, traditional healers, etc.) and receive training on Psychological First Aid, provision of basic emotional support and referral mechanisms. Additional capacity building should be provided to ensure that participants can identify signs of distress and refer accordingly. Ongoing supervision should also be provided to all the participants to ensure the competence of providers according to humanitarian standards.

- Adults and adolescent participants of FGD requested more safe spaces for everyone: men, women, and children. Establishing more safe spaces would reinforce the engagement of the community in diversified activities and would strengthen resilient coping mechanisms.

- The provision of remote modalities of support can ensure continuity of services during times of heightened hardship, such as imposed lockdowns due to Covid-19. Such measures, though necessary, can exacerbate existing mental health problems and disrupt access to mental health services, especially to those who are most in need.

- The concern that the host community is underserved was raised by many participants in FGDs. This issue could be tackled by increasing mobile MHPSS services and outreach in the host community. Implementing more services for the host community could also lead to the reduction of tension and fragmentation between the two communities. Mobile services could also be beneficial for Rohingya refugees living in camp areas and having limited access to services, such as women who are unaccompanied and tend to refrain from seeking assistance, even if it is vital for their well-being.

- Integration of MHPSS services and livelihoods projects, whenever possible, would be beneficial for the communities, as poverty and unemployment are part of the main stressors affecting their mental well-being. For example, CFW (Cash for Work) programmes support the communities and engage them in the provision of services while building on their capacities.

- Reinforce the collaboration between governmental, inter-governmental and non-governmental agencies would avoid any duplication in the provision of services while ensuring the sustainability of services in the long term through the national health care system of Bangladesh.

- MHPSS services should be free for all the people of concern and when necessary, transportation should be provided or facilitated for referral services.

- All the MHPSS service providers should include gender and age considerations in the design and implementation of activities. For example, adolescents rely on their peers and therefore peer support groups can foster their resilience. Moreover, reaching adolescent girls in both communities is quite challenging due to the predominant perceptions related to their presence in the public space and their role within families and communities. Given that their mobility is limited, it is useful for them to have access to services that are close to their residence or facilitate their access in another way, as this allows them to participate, create networks and eliminate the risk of isolation.

- As misinformation continues to erode the resilience of communities, it is encouraged that actors invest considerable resources in the provision of clear information to the communities.

- MHPSS service providers, including local actors, should engage in capacity-building initiatives and ongoing supervision to ensure that their practices are aligned and respect all the humanitarian principles. The capacity building of local stakeholders will also enhance sustainability.

- Community support MHPSS activities should be prioritized by actors as such activities promote resilience and adaptation of positive coping mechanisms and can strengthen the existing social networks. This type of activities enables resilient coping mechanisms through conflict mediation, social cohesiveness and restoring of trust within communities. "Communities can be drivers for their own care and change and should be meaningfully involved in all stages of MHPSS responses. Emergency-affected people are first and foremost to be viewed as active participants in improving individual and collective well-being, rather than as passive recipients of services that are designed for them by others. Thus, using community- based MHPSS approaches facilitates families, groups and communities to support and care for others in ways that encourage recovery and resilience. These approaches also contribute to restoring and/or strengthening those collective structures and systems essential to daily life and well-being." (IOM, 2019)

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