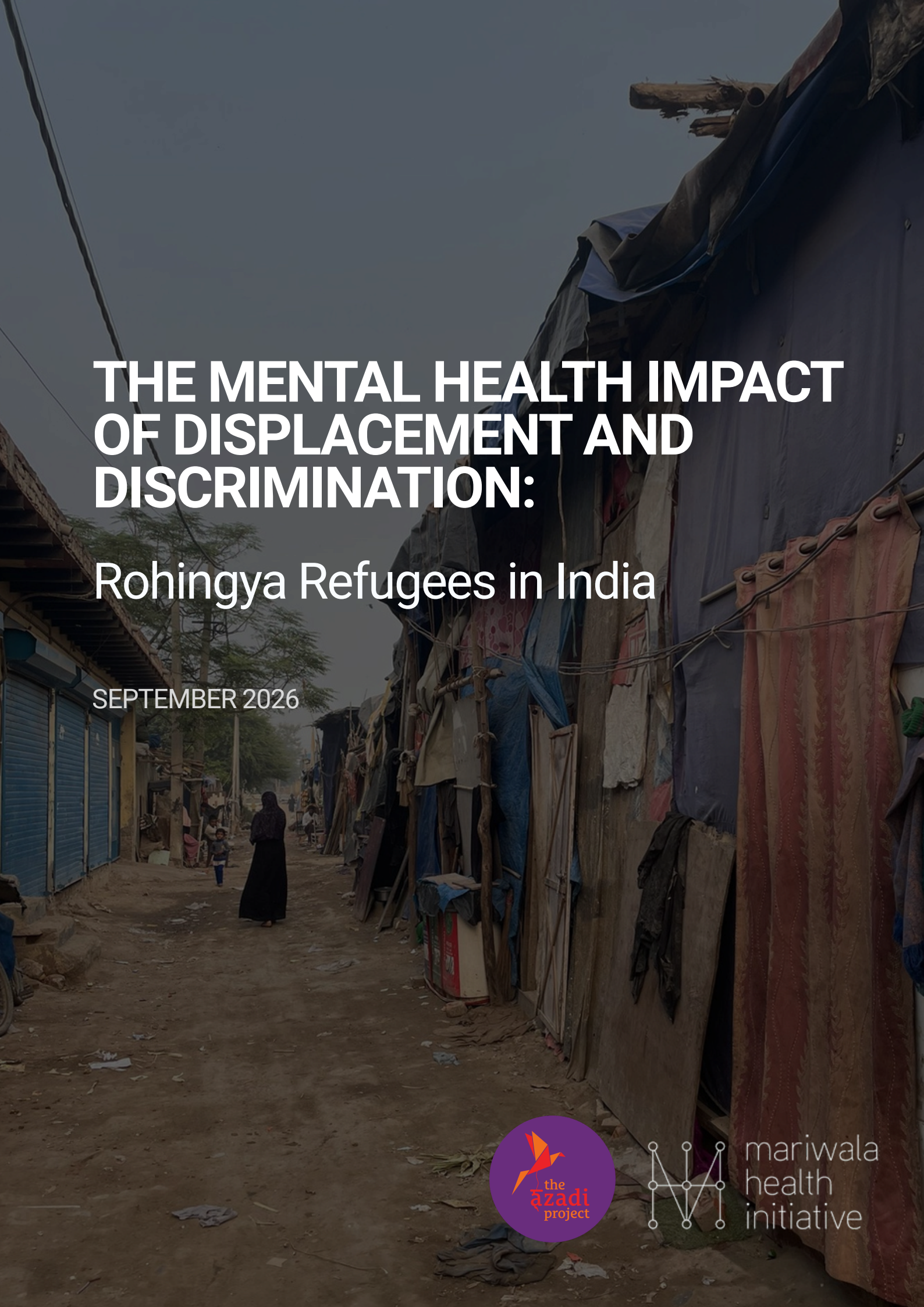


THE MENTAL HEALTH IMPACT OF DISPLACEMENT AND DISCRIMINATION:

Rohingya Refugees in India

SEPTEMBER 2026

the Azadi project

mariwala health initiative

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Supported By

Mariwala Health Initiative (MHI)

Content Warning

This report includes mentions of traumatic experiences of Rohingya refugees and of self harm and violence, which may be distressing for some readers. In case the material is triggering, please reach out to iCALL at 9152987821 (Available from Monday to Saturday between 10 AM to 8 PM)

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EXECUTIVE SUMMARY

> We can’t sleep because we’re so scared. Many of us have constant headaches, high blood pressure and trouble breathing.

A Rohingya refugee woman living in Hyderabad, India

The Rohingya refugees in India are living through one of the most overlooked humanitarian crises in South Asia. Forced to flee decades of persecution in Myanmar, they now face new forms of insecurity in refugee settlements and detention centers in India. The Rohingya refugees are an ethnic Muslim minority from Buddhist-majority Myanmar. Due to their Muslim identity, they do not qualify for protection under India's new Immigrants and Foreigners Act, 2025. This law provides a pathway for minority groups (Hindus, Sikhs, Buddhists, Jains, Parsis, and Christians) from Afghanistan, Bangladesh and Pakistan who entered India before Dec 31, 2024 to stay without valid papers in India. The Indian state treats Rohingya refugees as part of a larger group of "illegal Muslim immigrants," lumping them together with undocumented immigrants from Bangladesh, even though the two groups are very different in terms of ethnicity, language, and history. This creates further hostility towards Rohingya refugees living in India.



Map not to scale

This research builds on The Azadi Project's previous and independently conducted research on the detention of Rohingya refugees in India. This report examines the often overlooked mental health consequences of displacement and prolonged uncertainty experienced by Rohingya refugees. Conducted across seven key locations: Delhi, Jammu (Jammu & Kashmir), Hyderabad (Telangana), Haryana, Assam, West Bengal, and Uttar Pradesh- this research documents the multiple and intersecting challenges confronting the Rohingya refugee community.

This includes acute psychological distress, denial of healthcare, environmental hardships, and the unique vulnerabilities faced by persons with disabilities. Together, these conditions create a cycle of deprivation that undermines every aspect of their daily life, violates basic human rights, constitutional rights of non-citizens in India and highlights India's failure in upholding its obligations under the principle of non-refoulement, International Covenant on Civil and Political Rights and several other international human rights conventions that it is a party to.

Women, children, and persons with disabilities remain the most at risk as the convergence of detention, inadequate healthcare and climate stress compounds their vulnerability. The recent withdrawal of international aid following U.S. funding cuts has further stripped communities of essential support, leaving them to navigate growing hardship with little or no institutional help. Across all sites, the research finds a consistent pattern of human rights violations and systemic neglect, where refugees are denied dignity, protection, and access to basic services despite holding UNHCR refugee cards.

The research highlights a mental health crisis within Rohingya communities.



83.3%

respondents reported feeling fear as a constant emotion.



50.9%

experience anxiety or stress "always", on a daily basis.

Rohingya refugees in India report living in constant fear, especially following the illegal deportations of 140+ Rohingya refugees from Delhi and Assam to Myanmar and Bangladesh respectively in May 2025. Fearing a similar fate more than 150 families have left India from the period of May 2025 to September 2025. Feelings of hopelessness and social isolation are pervasive, with

100% **of respondents reporting experiences of discrimination.**

Moreover, in recent months, authorities in states such as Telangana have instructed UNHCR to halt the registration of new Rohingya refugees. Local or UNHCR-supported organizations have also been asked to discontinue their interventions with Rohingya refugee communities. These developments have further limited access to protection and support services for the community.

Additionally, access to healthcare remains severely limited. Accessed medical reports showed a high prevalence of Hepatitis B and C, kidney and liver disorders, thyroid disease, and malnutrition, mental health ailments including dissociative disorders among the Rohingya refugee population living in India. However, being denied a national ID card such as the Aadhaar card and non-acceptance of their UNHCR cards in government hospitals has meant that the Rohingya refugees in India are forced to live with chronic conditions without treatment and medication and end up suffering the worst symptoms and impacts of their illnesses. Moreover, no access to formal sources of employment and restricted access to informal labor work make it more difficult in accessing health-related treatment due to severe financial challenges.

Climate and environmental stressors exacerbate these vulnerabilities. Extreme heat and recurring monsoon floods further threaten health, safety, and livelihoods. Our findings show that lack of clean drinking water, unreliable water tanker supplies, and absence of electricity lead to sleeplessness, dehydration, and waterborne infections. The cessation of aid from local UNHCR- partner organizations in India following U.S. funding cuts has further weakened community resilience.



Inside a makeshift shelter in a Rohingya refugee settlement, where access to electricity, water and proper cooking facilities remains scarce.



A Rohingya refugee girl at work cracking walnuts to help her family make ends meet, a reality that forces many refugee children out of classrooms and into labour.

Rohingya women and girls bear disproportionate burdens, facing menstrual hygiene challenges, heightened domestic labour, and increased domestic violence. Findings further reveal the compounded marginalization of refugees with physical and cognitive impairments. Most Rohingya refugees with disabilities reported experiencing stigma and facing complete dependence for their mobility and survival.



86.4%

of respondents shared that the challenges they face as refugees with physical and cognitive impairments cause significant distress and discomfort.

This research underscores the urgent need for immediate, coordinated action: restoring access to healthcare, legal protection, integrating mental health and disability-inclusive services, and strengthening resilience to climate-related threats. The Rohingya refugee crisis in India is both a humanitarian emergency and a human rights issue that demands urgent recognition and response aligned with international protection standards.



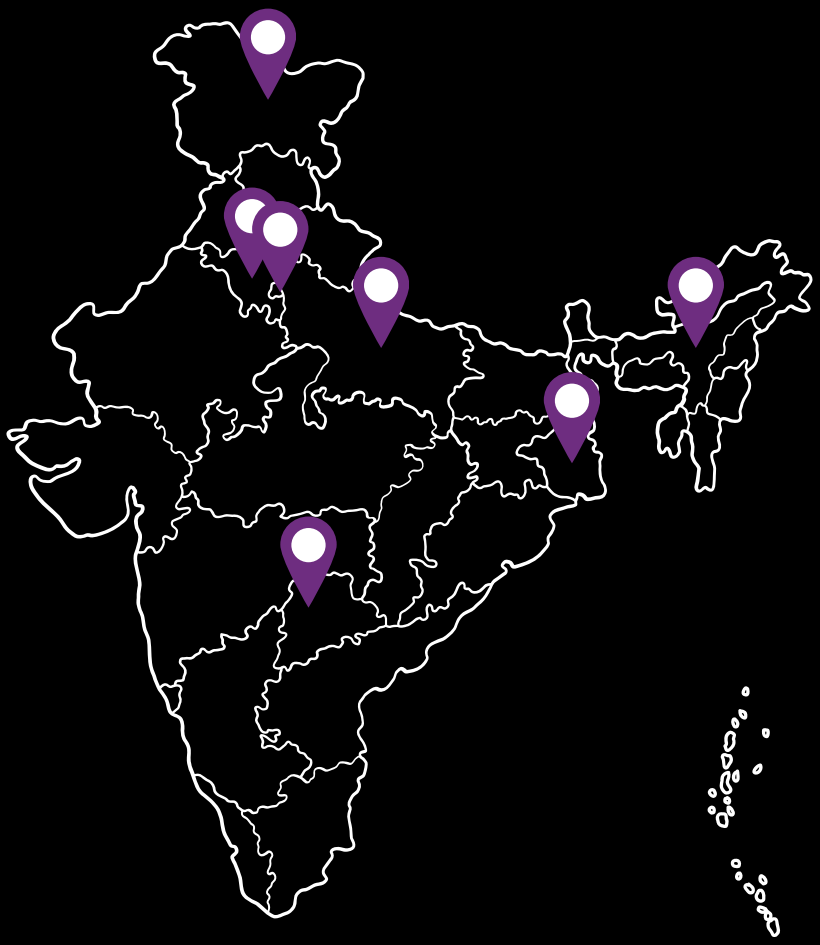
RESEARCH OBJECTIVES & METHODOLOGY

Research Objectives

Investigate and record the living conditions and intersectional vulnerabilities of Rohingya refugees across settlements in India, with particular attention to access to healthcare, climate-related challenges, mental health and the experiences of persons with physical and cognitive impairments.

Develop evidence-based recommendations for the Indian State, UNHCR, civil society organizations (CSOs) and International Ombudsmen to strengthen the protection of the rights and well-being of Rohingya refugees in India.

Methodology



This research was conducted across seven key locations in India.

1. Assam
2. Delhi
3. Hyderabad, Telangana
4. Jammu, Jammu & Kashmir
5. Haryana
6. Uttar Pradesh
7. West Bengal

These locations were strategically selected to reflect major Rohingya refugee settlements.

This research builds on The Azadi Project's previous and independently conducted research on the detention of Rohingya refugees in India. While drawing on earlier work that documented patterns, practices, and lived experiences of arbitrary detention, this study focuses on the mental health challenges faced by Rohingya refugees living in conditions of prolonged uncertainty. The research examines how legal precarity, displacement, discrimination and socioeconomic hardships collectively shape psychological well-being and everyday experiences among Rohingya refugee communities in India.

The research is based on primary data collection and employs a mixed-methods approach, integrating quantitative surveys with qualitative interviews. This methodological framework was chosen to provide a comprehensive and multidimensional understanding of the lived realities of Rohingya refugees in India. Quantitative data enabled the identification of broader trends relating to access to healthcare, physical and cognitive impairments, mental health challenges and climate-induced vulnerabilities. Qualitative interviews, meanwhile, offered in-depth insights into personal experiences and social dynamics that are often not visible through quantitative data alone.

The research adopts an intersectional lens to understand the multiple and overlapping forms of marginalization experienced by Rohingya refugees. While the research sought to capture diverse experiences within the community, it was unable to identify or document the experiences of individuals identifying as trans, non-binary, or gender-fluid.



A psycho-social workshop with Rohingya refugee kids in Jammu, India

Furthermore, the research deliberately steers away from a diagnostic understanding of mental health, instead examining how political uncertainty, displacement, discrimination, statelessness and existential insecurity shape mental health and psychosocial well-being. Moreover, the research reflects variation in sample sizes across thematic sections. This is due to the differing relevance of each issue to the study population, the availability of eligible participants and the use of purposive sampling. These variations are consistent with the study's objective of obtaining rich, context-specific information from participants who were most comfortable and could speak on the issues rather than achieving uniform sample sizes across all sections.

A central feature of this research methodology is its commitment to community-led and participatory research. So, a core research principle was that Rohingya refugees should not be treated solely as research subjects, but recognized as producers of knowledge with their own lived realities.

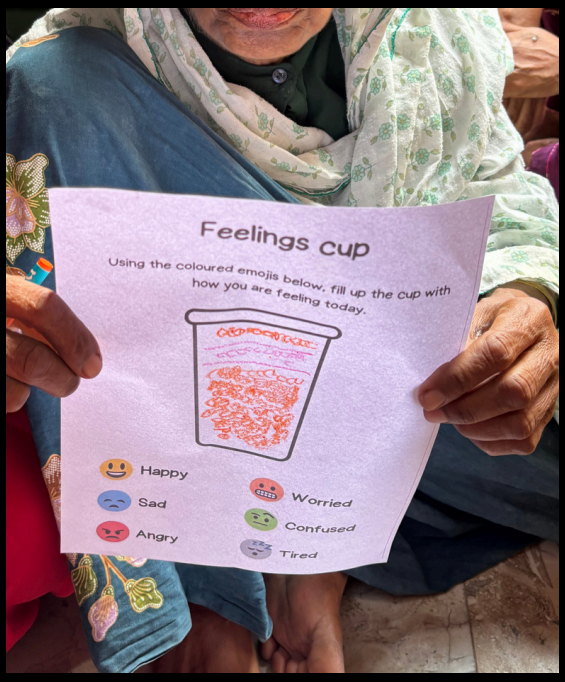
Accordingly, the research centered their experiences and agency by engaging and training community researchers (volunteers) from within the Rohingya refugee community. These community field researchers were actively involved across all stages of the research process, mainly conceptualization, survey development, documentation, data-gathering and analysis.



Refugee Settlement in Jammu, India

The study was further guided by an advisory committee that provided oversight and input at key stages, particularly during research design and drafting. The committee included two members with lived experience of displacement and two members with relevant technical expertise.

Recognizing the emotionally demanding nature of engaging with such sensitive themes, dedicated mental health support sessions were provided to the community field researchers. These sessions were intended to support the well-being of the field researchers, offer spaces for reflection and coping strategies. Prior to commencing fieldwork, a series of virtual training sessions were organized and facilitated by the Mariwala Health Initiative (MHI) for both the community field researchers and The Azadi Project team. These sessions covered research ethics, informed consent procedures, data-gathering techniques, documentation and reporting practices. Particular emphasis was placed on conducting interviews mindfully and ethically, especially while engaging with sensitive themes such as trauma, loss, discrimination, mental health challenges and rights violations. Researchers were trained to recognize and minimize the risk of re-traumatization and to remain attentive to participants' physical and emotional well-being throughout the research process.



Psychosocial Support Activity with Community Women



Psychosocial Support Activity with Community Women

The learnings and insights from these training sessions were further disseminated by The Azadi team to all other field researchers who volunteered and contributed to the research at subsequent stages.

Furthermore, the research was guided by the principles of informed consent, confidentiality, cultural sensitivity and collaboration. Before each interview, participants were informed about the purpose and scope of the research and their voluntary participation. Age-appropriate assent from minors with parental/guardian consent was sought, while verbal consent was obtained from adult participants. Interviews were conducted using language appropriate to the child's developmental stage, with participation being entirely voluntary. Children were informed that they could decline to answer any question or withdraw from the interview at any time. Particular care and continuous assent was taken when discussing sensitive topics and confidentiality was maintained throughout the study. For adult participants, additional consent was sought when discussions involved particularly sensitive topics, including traumatic experiences, existential insecurity and violations of rights.

RESEARCH TECHNIQUES

Semi-Structured & Unstructured Interviews

These interviews combined guided questions with open-ended conversations, allowing participants to share their experiences in their own words while maintaining consistency across key thematic areas. This approach facilitated both comparability and rich narrative accounts.

Field Observations

Field observations by researchers provided critical context for the research findings. These observations documented living conditions, community dynamics, access to services, and less visible or intangible forms of vulnerability, such as fear, isolation and psychosocial distress, offering a more nuanced understanding of the everyday realities faced by Rohingya refugees.

Community Engagement

Community engagement formed a key component of the research methodology. Recognizing the visible precarity and vulnerability experienced by many members of the community, The Azadi Project sought to ensure that the research process was accompanied by meaningful forms of support. The team organized mental health and psychosocial support (MHPSS) activities, menstrual health workshops, and community well-being initiatives across several settlements. These engagements not only strengthened trust and relationships that were essential for data collection but also reflected a commitment to reciprocity and care toward communities that shared their experiences and time with the research team.

In collaboration with Mariwala Health Initiative (MHI), enhanced care mechanisms incorporating both mental health and physical health support were extended to Rohingya refugee settlements in Delhi, Hyderabad, and Mewat. Importantly, the allocation of these support mechanisms was entirely delinked from participation in the research. The Azadi Project team independently identified and prioritized the most vulnerable individuals and families through community visits and assessments.

RESEARCH TECHNIQUES



Art Therapy Session with the community

RESEARCH TECHNIQUES

Community Engagement

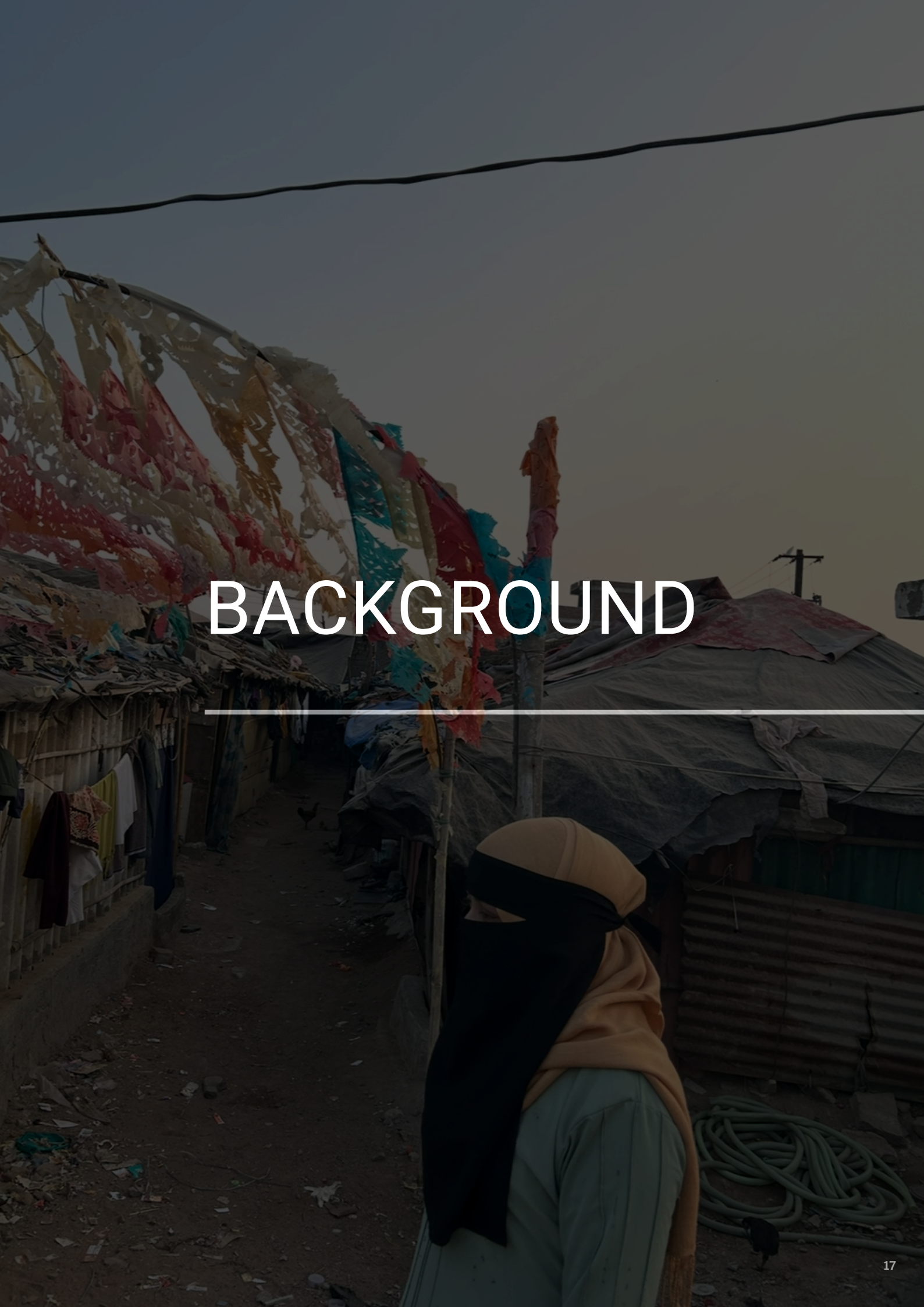
To further support community well-being, Mental Health and Psychosocial Support (MHPSS) sessions were conducted in settlements across Delhi, Hyderabad, Jammu, and Mewat. Drawing on guidance and strategies from mental health experts at MHI, these sessions explored collective coping strategies, group therapy and art-based therapeutic activities. Additional community support initiatives included the distribution of menstrual hygiene products, refreshments during Ramadan, and winter clothes and blankets in Delhi settlements.

Case Studies

Selected individual and family case studies provided detailed insights into the lived realities of Rohingya refugees. These case studies enabled a deeper exploration of personal trajectories, structural challenges and coping mechanisms while highlighting both recurring patterns and unique circumstances.

Document Analysis

The research also involved reviewing existing literature and relevant legal and medical reports of participants. This analysis helped situate primary findings within broader legal, political, and institutional frameworks.



BACKGROUND

The Rohingya, a stateless Muslim minority originating from Myanmar's Rakhine State, represent one of the world's most persecuted and displaced populations, with an estimated 2.8 million[1] people. Decades of institutionalized discrimination, denial of citizenship, and recurrent episodes of state-sponsored persecution have driven successive waves of displacement, particularly since the 1990s.

Significant episodes of forced migration occurred in 2012 and 2017, coinciding with large-scale military crackdowns widely documented as acts of ethnic cleansing and genocide. These events led to the mass exodus of Rohingya refugees into neighboring countries. Although the United Nations High Commissioner for Refugees (UNHCR) reported a small-scale voluntary return of Rohingya refugees to Myanmar in May 2025 with approximately 82 individuals[2] returning to Rakhine State, the broader outlook for repatriation remains bleak. Since late 2023, renewed conflict between the Myanmar military junta, which seized power in February 2021 and the Arakan Army in Rakhine has further destabilized the region. According to Human Rights Watch, all parties involved have committed serious human rights violations. The Arakan Army, which now controls significant parts of Rakhine, has also escalated repressive actions against Rohingya civilians. This further reduces the prospects for a safe, voluntary return of Rohingya refugees.

The Rohingya people continue to seek refuge across the region. Bangladesh hosts the largest share, with an estimated 1,156,001 individuals[3] residing primarily in refugee camps in Cox's Bazar that are overcrowded and plagued by violent crimes and crimes against women and girls. Countries like Malaysia, Indonesia, and Thailand also host a combined total of approximately 122,100 Rohingya refugees[4].

India has also seen a steady influx, particularly between 2012 and 2016, when at least 13,000[5] Rohingya people crossed over, from Myanmar and Bangladesh. The closure of key border crossings by Bangladesh authorities in 2013 further compelled Rohingya families to seek alternative migratory routes, including via the India-Myanmar border, the India-Myanmar-Bangladesh tri-junction and porous corridors across Northeast India. Additionally, the 2017 military-led genocide in Myanmar intensified this movement as India became a desired destination due to its perceived political secularism, economic opportunities and relative safety. However, a significant number of Rohingya women and children were trafficked or smuggled into the country during this period. Although, many reported leaving due to increasing violence as well as deteriorating conditions where they were denied basic support such as shelter, food rations and protection within the camps in Bangladesh.

Today, an estimated 23,300[6] Rohingya refugees are registered with UNHCR in India, residing in dispersed, informal settlements across several states. Despite their presence, most remain without legal status or access to consistent support, facing ongoing challenges related to security, livelihood and integration. According to the UNHCR, until 2012[7], Rohingyas in India could apply for asylum and were issued Long-term Visas (LTVs) by the Indian government. However, since 2017[8], the Indian government has increasingly stopped recognizing UNHCR cards, viewing Rohingya as illegal immigrants subject to detention and deportation. Moreover, the government has stopped issuing or renewing[9] these visas for Rohingya refugees, exacerbating their already vulnerable status[10]. This was soon before a high-ranking politician filed a petition in the state High Court of Jammu & Kashmir seeking identification and deportation of Rohingyas from Jammu. This triggered public campaigns and fueled vigilante-style attacks and xenophobic rhetoric. Over the years, hostile media narratives and discriminatory policies have deepened the stigma against the Rohingya. Political leaders[10] have denied them refugee status, while national media often label them as “ghuspetis” (illegal infiltrators), further endangering their safety. In the absence of a standardized refugee policy until The Immigration and Foreigners Act, 2025, Rohingya refugees have faced arbitrary treatment, putting them at constant risk of detention and deportation. Hundreds of Rohingya refugees including pregnant women, minors, children and elderly have been indefinitely detained across jails[11] and detention centers across India.

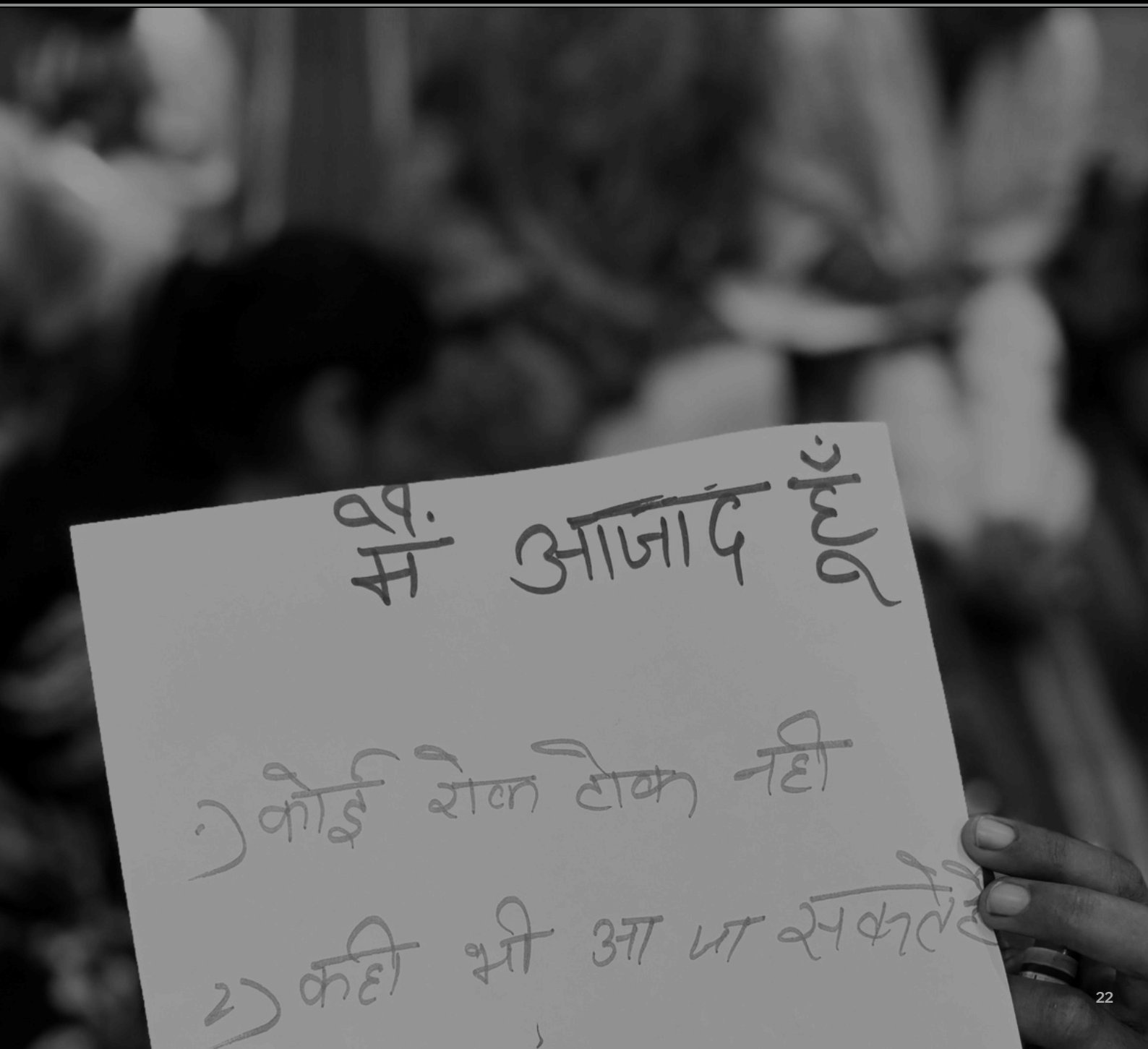
Over 100 of them were held at the Matia Transit Camp[12] in Goalpara, Assam, the largest detention center in the country which became operational in 2023. However, on May 6, 2025, several Rohingya detainees at Matia were illegally deported to Bangladesh with their money and belongings allegedly taken by Indian security forces before being pushed across the Bangladesh border. On the same day, another 40 Rohingya refugees were arrested, detained and flown from Delhi in handcuffs and blindfolds to the Andamans. From there they were allegedly taken on a naval ship and dropped into the sea short of Myanmar. This is not only against the principle of non-refoulement as part of customary international law (opinio juris), which applies to all states irrespective of treaty ratifications but also violative of India's constitutional provisions (particularly Article 21) which is applicable to both citizens and non-citizens.

Our interviews with several Rohingya camp leaders and community members revealed that over 150 Rohingya refugee families have self-deported themselves since May 2025. They are afraid of being illegally detained or forcibly sent back to Myanmar. However, 10 families attempting to self deport to Bangladesh were detained at the Dum Dum Central Jail. Their fear is made worse by xenophobic news headlines and political fear-mongering. There is also deep fear about being indefinitely separated from family members. Detention and deportation often leads to families being split up, especially parents and children.

> "We can't sleep because we're so scared. Many of us have headaches, high blood pressure, and trouble breathing. I'm always tense and afraid because we've heard that children are separated from their parents during deportation. That's why we feel threatened every day."
>
> A Rohingya mother living in India

FINDINGS

Implications on Mental Health



Findings: Implications on Mental Health

The Rohingya refugees have faced decades of persecution, violence, forced displacement and statelessness. While their troubled past leaves deep psychological scars, their current living conditions continue to shape and worsen their psychological well-being. Rohingya refugees in India live with a constant fear of detention, deportation and family separation. **Their access to fundamental necessities like clean and regular water supply, housing, sanitation, education, as well as to essential services like healthcare and legal protection is stripped away from them. Moreover, a lack of legal recognition and their constant portrayal as 'ghuspethis' (illegal immigrants) by the state and mainstream media leaves many feeling unwanted and invisible.**

Such **firsthand and recurrent experiences of xenophobia, social isolation and instability** undermine self-esteem, erode people's sense of dignity and deepen feelings of alienation. Due to the **continuous uncertainty, it makes it difficult for individuals to feel safe, especially children growing up with no sense of safety, normalcy or plan for the future.**

STUDY DEMOGRAPHICS

N: 108

Age Group: 16 - 60

Locations:

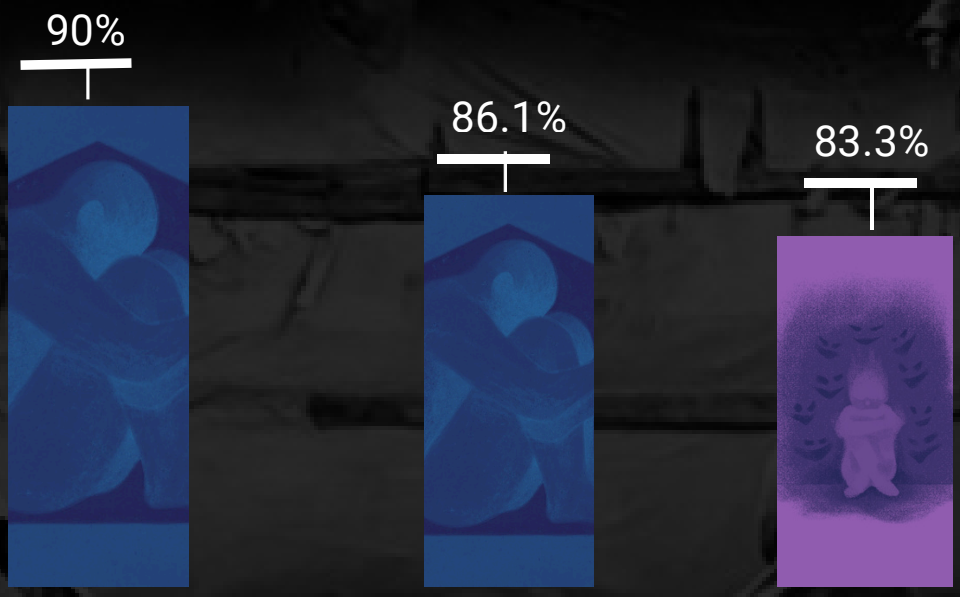
1. Delhi
2. Hyderabad, Telangana
3. Jammu, J&K
4. Haryana
5. West Bengal

To live in a constant state of fear can lead to chronic stress, anxiety, hopelessness and emotional exhaustion. As a result, **the mental health challenges faced by Rohingya refugees should not be understood or seen as only a response to past traumatic events but also a response to the realities of everyday life in India.** For many refugees, it is this ongoing struggle for basic security, stability and dignity that continues to weigh heavily on their mental wellbeing.



Findings: Implications on Mental Health

Fear stands to be a dominant emotion, with 83.3% of respondents saying they feel it frequently. Additionally, almost 90% of refugees report feeling "very unsafe", while a smaller percentage (9.3%) feel "unsafe" due to constant threats of deportation and detention. The illegal deportations of 140+ Rohingya refugees from India in May, 2025, has induced severe stress and anxiety amidst the population, with 86.1% of respondents reporting these feelings either always (on an everyday basis) or often (several times a week).



report feeling unsafe due to constant fear of deportation and detention

feel severe stress and anxiety either daily or several times a week

report fear as a dominant emotion that they feel frequently

During interviews, discussions about daily challenges frequently expanded into reflections on loss, uncertainty and the future. Their current conditions have snatched their sense of agency and future.

Across interviews, respondents often spoke not only of immediate hardships but also of a growing sense of purposelessness and uncertainty about what lay ahead.

Many participants described feeling unable to exercise control over key aspects of their lives, including their safety, livelihoods, family relationships and long-term life prospects.

Findings: Implications on Mental Health

One participant, whose family members were forcibly deported to Bangladesh in May 2025, described **intense grief following their separation and reported experiencing thoughts of suicide as a means of escaping his emotional pain**. Other respondents expressed a sense of **being trapped**, **unable to make meaningful change in their circumstances.**

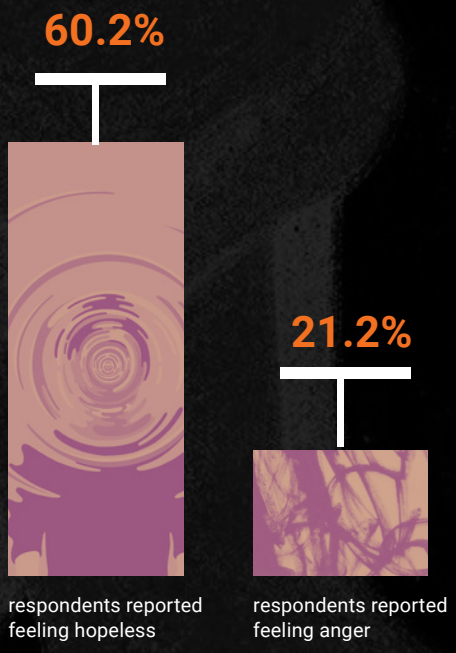
These experiences were particularly pronounced among respondents **living with disabilities**.

> **I don't understand why I am even alive. I cannot earn for my daughters or do anything to bring us out of this state.**

A participant with visual impairment shared

Such accounts reflect not only material hardship but also the psychological burden of feeling unable to fulfil familial roles. **The absence of stable livelihood opportunities emerged as a major source of distress.** Months without income had transformed initial feelings of anxiety into hopelessness for many respondents.

Feelings of hopelessness (60.2%) and anger (21.2%) were very commonly reported. Some respondents also expressed feeling a sense of helplessness and emotional burden as they witnessed the ongoing suffering of their loved ones and were unable to protect or support them.

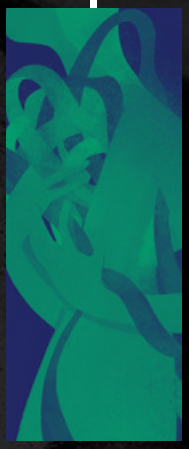


Findings: Implications on Mental Health

The triple marginalization of being refugees, a religious minority, and lacking legal recognition in India adds an additional layer of existential threat to them.

For many, the inability to cope with their experiences as refugees is stark. 60.2% reported feeling unable to cope on a daily or near-daily basis (always), while a further 23.1% reported feeling unable to cope several times a week (often).

60.2%



reported struggling to cope with their experiences as refugees every day or nearly every day.

23.1%



respondents reported struggling to cope with their experiences as refugees several times a week.

> **I feel severely isolated because of the way our community is treated. I often hear that we do not belong here and should leave India. This makes me feel very sad and disrespected.**
>
> A respondent shared

In addition to fear, a deep **sense of isolation** pervades the community. Rohingya refugees report being treated as outsiders, with **all 108 respondents (100%) reported facing discrimination as refugees.** With the media portraying them as illegal immigrants or 'ghuspetis', one respondent explained **how the constant narrative that they "do not belong here" leads to a lack of self-worth**. This social alienation exacerbates their mental health struggles contributing to a sense of invisibility.

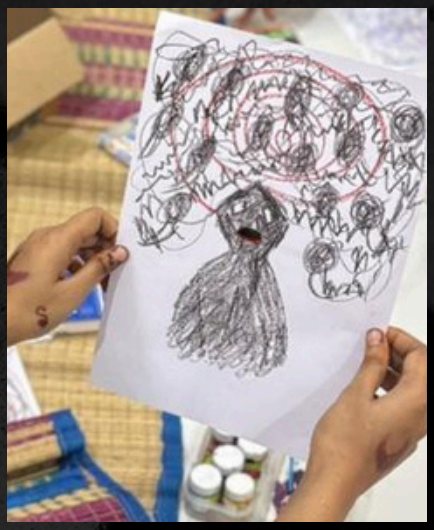
100%



reported facing discrimination as refugees

Intersecting Vulnerabilities

Women refugees face an additional layer of vulnerability due to the cumulative effects of gender-based violence, intimate partner violence, unique health challenges such as menstrual difficulties, and the often less visible forms of state-inflicted violence. These intersecting experiences create an overwhelming burden that worsens mental health challenges.



A Rohingya refugee woman's illustration of her inner world

Rooted in a patriarchal household setting, women refugees also carry significant caregiving responsibilities while navigating poverty, legal precarity, instability and no sense of safety or future of their families. The pressure to provide emotional and practical support to children, spouses and elderly relatives, despite having limited resources and support themselves, can contribute to chronic stress, anxiety and emotional exhaustion. Fear of detention, deportation, family separation, and barriers to accessing healthcare, education, and livelihood opportunities further add to their psychological distress.

The intersection of gender, refugee status, religious minority identity and lack of legal recognition makes it more difficult for women to seek help or recover from traumatic experiences, especially with the lack of adequate support mechanisms. One woman, who is a victim of intimate partner violence, described waking up each day feeling as if she could not breathe.

> **I feel constant fear and a lot of shame; there's no one to turn to. Every day feels like a battle, not just with him but with my own mind.**

A Rohingya refugee woman experiencing intimate partner violence shared

Findings: Implications on Mental Health

Testimonies from **Rohingya refugees with physical and cognitive disabilities** reveal the unique challenges they face in navigating overcrowded settlements and accessing livelihood opportunities. These barriers contribute to feelings of dependence, isolation, and helplessness. The intersection of refugee status with disability creates distinct forms of psychosocial vulnerability.



A drawing by a Rohingya refugee woman depicting togetherness and solidarity

> **I feel trapped and frustrated. The activities we take for granted such as earning a living and moving freely are also hard for me. There is no support for people like us.**

shares a physically handicapped participant

Moreover, the **impact of environmental factors on mental health** is also evident. Participants share that sleeplessness is a recurrent issue during summer due to excessive heat and their access to electricity. Several share that due to this, they feel irritation, dizziness, lack of zeal to work.

Findings: Implications on Mental Health

However, there are pockets of hope. In areas such as Delhi, Hyderabad (Telangana), and Haryana, where local and regional organizations have implemented mental health and psychosocial support (MHPSS) interventions, refugees reported fair to good access to mental health services.

As part of this research, **the The Azadi Project team conducted community-based mental health workshops across these locations**. The workshops were **facilitated by trained community field researchers**. It included group discussions, art-based therapeutic activities and conversations aimed at challenging mental health stigma within the community. Coping strategies and self-care practices which were shared by mental health professionals from **Mariwala Health Initiative** were also incorporated into these sessions. The participants engaged openly in discussions about their emotional well-being, sharing experiences of anxiety, fear, grief and chronic stress.

> **We never knew mental health existed. We thought the way we feel is simply life. After these sessions I finally understand my emotions and why I feel this heaviness. It has given me clarity and hope.**

One of the participants shared

> **We lived in fear for so long. We did not share our worries because we believed no one would understand us. Now when we speak, it feels lighter. It feels comforting to know there is someone who listens without judgement.**

Shared by another participant

Findings: Implications on Mental Health

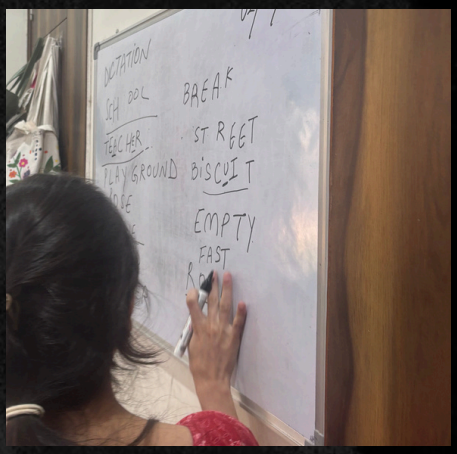
A frequent request among the participants was for more such workshops where they could have a safe space to release their emotional burden. This reflects both the unmet need for psychosocial support and the value of community-based spaces for collective healing.



A Psychosocial support session with Rohingya Refugee Women facilitated by The Azadi Project along with a local organization

At the same time, the workshops revealed the psychological impact of the recent deportations. Participants repeatedly described feeling extreme fear and feelings of insecurity following these events. Women in particular spoke about living with a constant fear of detention or deportation and the anxiety of not knowing when their families might be affected. These concerns have extended beyond emotional distress and into everyday life. Participants reported restrictions on movement, reduced opportunities to seek work, and fears associated with leaving their settlements. Such conditions lead to a persistent feelings of stress, anxiety and emotional exhaustion that further detriments mental well-being and worsens existing trauma.

Long-term interventions in Delhi and Hyderabad with Rohingya women have offered safe and supportive spaces where they can process difficult experiences and build coping mechanisms. The Azadi Project with support from MHI, collaborated with local partners to conduct individual counselling and group therapy sessions which included guided discussions, relaxation techniques and peer-support activities. For women facing severe distress or complex trauma, specialized care is provided with the help of trained psychologists. Art therapy has been an important component of these efforts, enabling women to communicate emotions and experiences that may be difficult to articulate verbally.



Functional Literacy Session for Rohingya Refugee Women

Findings: Implications on Mental Health

> **I kept forgetting things and it created problems at home. I thought something was wrong with me. Through these sessions I learned it is linked to stress and trauma. With support, I visited a psychiatrist for the first time.**

Shared by one of the woman participants

Our observations from these programmes suggest that sustained MHPSS interventions hold a critical role in reducing social isolation, strengthening community support networks and fostering healthy emotional expression. Importantly, psychosocial support was integrated with broader empowerment initiatives, like vocational training, functional literacy and digital storytelling. This integrated approach recognizes that mental well-being is closely linked to a person's sense of agency, social connectedness and ability to dream a future beyond displacement and uncertainty.



Psychosocial Support Session for Children



Vocational Training: Teaching Crochet to Rohingya Refugee Women

Our efforts were also extended to provide psychosocial support to children through age-appropriate group sessions and supportive activities. These interventions help children process difficult emotions, build resilience and develop coping mechanisms as they navigate uncertain environments. Through these interactions, we identified several critical concerns, including racism and exclusion in school environments due to their identity as Rohingya, as well as exposure to domestic violence, with many children witnessing their fathers being abusive toward their mothers.

Findings: Implications on Mental Health

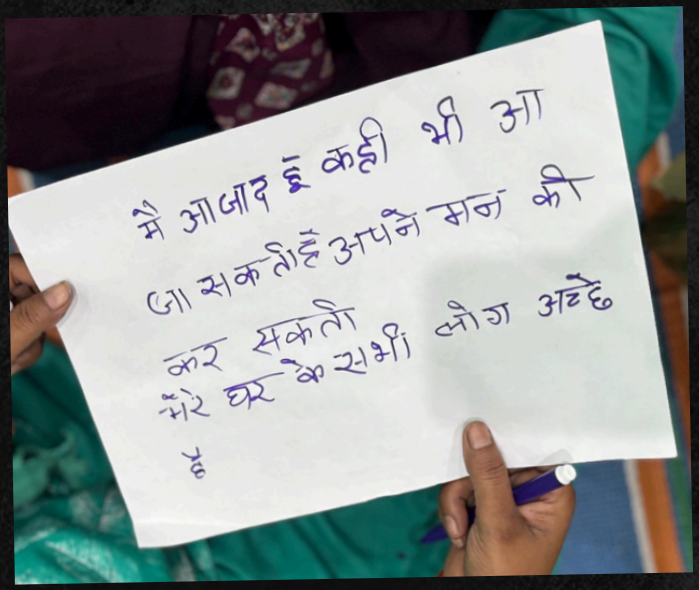
The documented violations faced by the community, including discrimination, exclusion from rights and services, threats of detention and deportation, family separation, and gender-based violence are not merely contextual factors but central determinants of mental health. These findings have important implications for mental health and psychosocial support (MHPSS) programming for refugee communities in India. While clinical and trauma-focused interventions are crucial, we need to move beyond individualized understandings of mental health especially with continuous experiences of distress and injustices. The experiences of Rohingya refugees highlight the need to adopt approaches that recognize the social determinants of wellbeing. This approach is also consistent with India's constitutional jurisprudence on the right to health. The Supreme Court of India has interpreted Article 21 of the Constitution - the right to life and personal liberty (which extends to aliens and citizens) to include the right to health, dignity and access to healthcare services. Within this framework, mental health becomes a rights-based obligation linked to dignity, protection and social justice. This principle is reinforced by the Mental Healthcare Act, 2017, which explicitly recognizes the right of "all persons" to access mental healthcare and treatment[13]. The Act guarantees access without discrimination and affirms that mental healthcare is a matter of rights, dignity and equality, rather than charity or discretionary provision.

MHPSS frameworks, interventions must therefore address not only symptoms of distress but also the conditions that produce and sustain them. This requires integrating mental health support with protection services, livelihood opportunities, gender-based violence response mechanisms and community-based social support systems.

Findings: Implications on Mental Health

The findings and past interventionary efforts by **The Azadi Project and Mariwala Health Initiative** also **underscore the importance of culturally responsive and trauma-informed programming** that recognizes the cumulative effects of forced displacement, violence and high legal-political-economic instability.

The community's positive reception towards the previously mentioned psychosocial interventions suggests that accessible, contextually grounded MHPSS programming can play a significant role in supporting refugee wellbeing. However, the findings also indicate that sustainable mental health outcomes will ultimately depend not only on expanding service provision but also on addressing the structural factors that place Rohingya refugees at risk, in line with the constitutional commitment to the right to health and dignity.



A participant's reflection, shared during a psychosocial session with Rohingya refugee women.

CASE STUDIES

Case Study : 1

(Using pseudonyms to ensure safety, privacy, and confidentiality)

Amina is a 17-year-old Rohingya refugee girl living in a small, crowded settlement on the outskirts of an Indian city. She was born here, and India is the only home she has ever known. Yet, she lives every day with the fear that she and her family could be taken away. Her parents fled Myanmar before she was born, escaping unimaginable violence.

As Amina was sharing about her experiences, her eyes were swollen and red; she had been crying before arriving. She shared how police officers often patrol her neighborhood on bikes, watching their homes, asking questions and checking documents. She said she feels their eyes on her even when she walks back from her coaching classes.

> **It feels like we are criminals, they are waiting for us to do something wrong.**

As Amina was sharing about her experiences, her eyes were swollen and red; she had been crying before arriving. She shared how police officers often patrol her neighborhood on bikes, watching their homes, asking questions and checking documents. She said she feels their eyes on her even when she walks back from her coaching classes.

Amina is in class 9, and her exams are going on. She wants to do well, to study hard but the situation around her makes it almost impossible. There is no steady electricity in her “jhuggi,” and she often studies by candlelight. The constant tension, the noise of police patrols and the uncertainty about their future make it hard for her to focus. Despite all this, she meets with her friends to study together, sharing books and encouraging each other to keep going.

As she spoke, Amina described feeling tired all the time, unable to sleep, and constantly worried about what might happen next. Though she was born in India, as a refugee she does not feel like she belongs anywhere.

CASE STUDIES

Case Study : 1

(Using pseudonyms to ensure safety, privacy, and confidentiality)

Amina's narrative highlights the significant mental health consequences of prolonged displacement , legal precarity and chronic exposure to uncertainty. Persistent fear of detention and experiences of being treated as a security threat contribute to heightened anxiety, hypervigilance and a diminished sense of safety and belonging. Structural barriers like overcrowded living conditions, unreliable access to electricity and disruptions to education, further affect her education, academic performance and ability to plan for the future. She reported symptoms of chronic stress including sleep disturbances, constant worry, emotional exhaustion, along with feelings of identity insecurity. While at the same time, her peer relationships emerged as an important protective factor. Studying collectively, sharing resources and offering mutual encouragement appeared to foster resilience and give a sense of emotional support in an uncertain environment.

Thus, what Amina's experiences illustrate is how refugee adolescents' mental health is shaped by intersecting structural determinants, including legal insecurity, discrimination, socioeconomic deprivation and social exclusion. It reveals how the impacts of displacement extend beyond material hardships, affecting young people's emotional well-being, sense of self and future orientation.

CASE STUDIES

Case Study : 2

(Using pseudonyms to ensure safety, privacy, and confidentiality)

Kismatara Begum is a 23-year-old Rohingya woman living in a refugee settlement in India. She has been diagnosed with Dissociative Identity Disorder (DID). She described frequent, intense head pain, which she associates with her dissociative episodes, moments when her sense of identity and awareness fragment under overwhelming stress. Kismatara shared that her condition has worsened since the illegal deportations of several Rohingya families from nearby camps in May 2025. She said that every report about the deportations brings back painful memories of the violence she witnessed in Myanmar, including the murders of people in her own village. As such memories resurface, she shares that she feels terrified and helpless.

The ongoing threat of deportation reactivates her past trauma, worsening her dissociative symptoms and physical pain. Kismatara's case highlights how the mental health of Rohingya refugees is not only shaped by past persecution but continually retraumatized by the insecurity and discrimination they face here.

> **What if they send me back?" she asked softly, tears filling her eyes. "I saw what they did there... I cannot survive that again.**

FINDINGS

Climate Vulnerabilities



Findings: Climate Vulnerabilities

Rohingya refugees in India primarily reside in informal settlements located on the peripheries of urban areas. **These settlements are often situated near wastelands or marginal land, where families live in flimsy, self-constructed shelters that provide limited protection from environmental exposure.**

Our survey, conducted across settlements in Delhi, Haryana, Hyderabad (Telangana), and Uttar Pradesh, highlights the protracted nature of displacement experienced by the community. Their **living conditions are further worsened by environmental and climate-related stressors, including extreme heat and seasonal flooding, which directly affect health, disrupt kids' education, daily livelihoods and constrain already limited income-generating opportunities.** Together, these factors intensify material insecurity and the overall vulnerability of households living in these settlements.

Extreme temperatures and flooding during the monsoons not only threaten their health but also disrupt their ability to earn a living and meet basic needs. 66% of Rohingya refugees reported unpredictable work conditions, which lead to serious financial struggles. 100% of the respondents highlighted the lack of access to clean drinking water, especially during the intense heat and monsoon seasons. There is no access to running water in individual spaces or the entire settlement. People rely mainly on water tankers, which are unreliable.

STUDY DEMOGRAPHICS

N: 47

Age Group: 16 - 60

Locations:

1. Delhi
2. Hyderabad, Telangana
3. Haryana
4. Uttar Pradesh

100%



reported the lack of access to clean drinking water during extreme heat and monsoons

66%

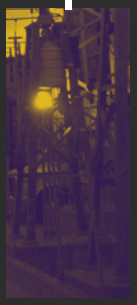


reported unpredictable work conditions, which lead to serious financial struggles

Findings: Climate Vulnerabilities

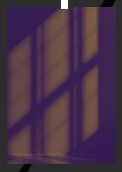
The lack of water compels refugees to buy water from outside, placing further strain on their already fragile finances. Electricity is also available sporadically.

64%



reported having access to 5-6 hours of electricity in a day

34%



reported having none at all

> **The water tank comes once a week, or at times not at all. After 10 days, it might come, but it's mostly unclean.**

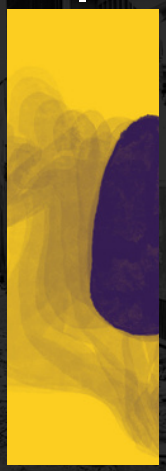
A Rohingya refugee woman in Delhi shared

> **In the summer, when the heat is unbearable, this makes everything even harder.**

Another respondent living in Delhi shared

The absence of electricity, particularly in the heat, makes life almost unbearable. 100% of the respondents reported difficulty sleeping, with sleeplessness leading to irritability, dizziness, and anxiety.

100%



respondents reported difficulty in sleeping

> **We rely on solar energy, but the battery runs out in the middle of the night, and the fan stops working, disrupting our sleep. Moreover, due to my physical health issues, I am unable to sleep properly too.**

Shared by another respondent

In the summer, the heat brings a range of health problems. Breathing difficulties, heat strokes, skin rashes, and dehydration are common, leaving many unable to perform their daily activities. Overcrowded living conditions and poor ventilation cause discomfort and stress.

> **In the summer, I cannot sleep at all. I have to wake up early to go to school, but due to improper sleep, I can't make it. I also experience headaches. Since my father is partially blind, he can't go out for work, and we struggle to manage our basic needs.**

A seventeen year old refugee shared

Monsoons bring additional hardships. Along with the lack of sleep and clean water, snake and insect bites are widespread. The unsanitary conditions, worsened by waterlogging and roof leaks, create a stench of stagnant water, encouraging the spread of disease.

> **We're plagued by waterborne infections at home. Poor living conditions in our community have taken a toll on our health. The streets are filled with garbage, making it a breeding ground for diseases.**

One respondent explained

Findings: Climate Vulnerabilities

Serious health issues, such as **kidney stones and typhoid have become common during the monsoon, largely due to poor water quality**. **Students face great difficulty in attending school, as the harsh conditions affect their ability to focus or attend classes**.

The community's access to aid has significantly decreased, particularly with recent cuts in U.S. aid. Previously, organizations like Action Aid offered some support, but this aid has now largely ceased.

The situation is **especially dire for women and persons with disabilities**. The lack of clean water and proper sanitation places women at heightened risk for **menstrual hygiene issues and reproductive health problems**. Many women are tasked with collecting water, which takes a physical toll. Additionally, **instances of gender-based violence (GBV) and intimate partner violence (IPV) are more frequent during such times**. During the interviews, women respondents share that due to **unemployment and the extreme weather, their partners often take out their anger on them,** sometimes even their children. **Persons with disabilities also face additional difficulties, as the challenging conditions make it harder for them to carry out basic activities in the settlement.** The compounded effects of extreme weather, poor infrastructure, and a lack of aid puts them at a double vulnerability and distress.

96%



respondents shared that the current environmental conditions compound their health struggles



A communal washroom and hand pump shared by 20 Rohingya families in Jammu, India

CASE STUDIES

Case Study : 1

(Using pseudonyms to ensure safety, privacy, and confidentiality)

Anuwara Begum, a 40-year-old Rohingya refugee single mother lives with her 3 children. To sustain her family, she works as a househelp but she shares how the extreme weather conditions and poor living environment have made daily life increasingly difficult.

> **The summer months are dreadful for my children and me.**

They have no access to electricity. As a result of this, they spend most nights sleepless and face chronic fatigue during the day. Her children frequently suffer from heat-related skin rashes and dehydration, while Anuwara herself experiences recurring urinary tract infections due to the lack of water. The absence of clean drinking water has caused her to develop kidney stones. Due to her financial challenges, she cannot afford to seek treatment. Moreover, the heavy rains bring roof leaks, waterlogging, and stagnant water, which makes their living space more unhygienic and prone to other infections. As a single mother, Anuwara Begum bears the dual burden of providing for her children while safeguarding their health in an increasingly unsafe environment.

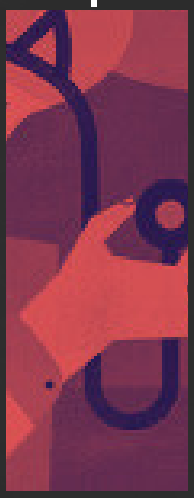
FINDINGS

Access to Healthcare



Findings: Access to Healthcare

100%



report being denied treatments for bigger health operations at government hospitals

28%



seek medical aid from private hospitals

STUDY DEMOGRAPHICS

N: 50

Age Group: 7-78

Locations:

1. Delhi
2. Hyderabad, Telangana
3. Haryana
4. Jammu, J&K

100% of respondents shared they they are denied treatments for bigger health operations at government hospitals as they only accept national ID proof i.e. Aadhaar cards. As a result, 28% of respondents seek medical aid from private hospitals but face great difficulty in completing their treatment due to severe financial constraints.

Many of them have been living with untreated health problems for years, some for 8 years, others for 5 or 2 years.

The most prevalent health issues in the community include **Hepatitis C, Hepatitis B, Kidney stones or failure, Liver infection, Fatty Liver and Thyroid.** Additionally, they face language barriers in hospitals, making it difficult for them to understand medical instructions and communicate their needs.

Findings: Access to Healthcare

The refugee settlements are typically located on the outskirts or in remote areas, hence accessibility to hospitals, both in terms of distance and fare poses a major challenge. Consequently, the **long journey and waiting hours at the hospital take up an entire day, which they cannot afford since most of them earn by the day**. 100% of respondents shared facing severe financial barriers in accessing the medical treatment they are prescribed. Only 6% of respondents report that they received One Time Allowance (OTA) only once from UNHCR which has stopped entirely now with the US aid cuts. Moreover, during interviews a lot of them shared seldom do they have access to food that meets their nutritional requirements.



100%

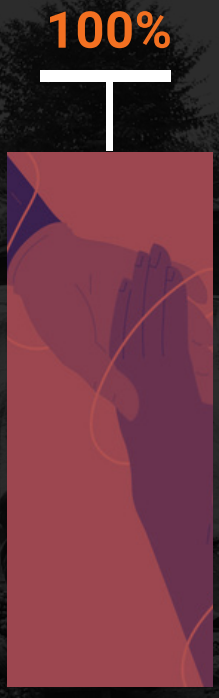
shared facing severe financial barriers in accessing the medical treatment



6%

report that they received OTA only once from UNHCR

The situation is even more challenging for people with disabilities. **100% of participants with disabilities reported being heavily dependent on others to take them to the hospital, as they cannot travel alone.** This dependency, combined with their existing health conditions, means their ailments only worsen over time. 100% of respondents reported that financial hardships make it impossible for them to afford the treatment they need, leaving their conditions to deteriorate without medical care.



100%

participants with disabilities reported being heavily dependent on others to take them to the hospital



100%

financial hardships make it impossible for them to afford the treatment

CASE STUDIES

Case Study : 1

(Using pseudonyms to ensure safety, privacy, and confidentiality)

A four-month old Rohingya refugee infant was born with acute jaundice and had undergone a gallbladder surgery when he was three months old. The father of the child shared that the infant's health started declining increasingly after the surgery. When the family took the infant to the emergency wing of a hospital in Delhi, they referred them to Kalawati Saran Children's Hospital for further pediatric treatment. The father reported that the infant remained admitted at Kalawati Hospital for 24 hours, but the hospital staff refused to provide adequate medical intervention, including oxygen support and active treatment. He claimed that staff members repeatedly cited the family's lack of Aadhaar cards, passports, or valid legal documents as the reason for withholding treatment.

According to the father's testimony, he repeatedly pleaded with the staff to place the child on oxygen support as the infant's condition visibly worsened. He stated that hospital personnel initially refused these requests and allegedly informed him that without an Aadhaar card, they could not easily receive treatment. He further shared that when he questioned why the child had been admitted if treatment would not be provided, staff members behaved disrespectfully and physically removed him from the room. The father stated that despite the child's worsening condition, hospital authorities neither initiated substantial treatment nor issued referral or transfer documentation to another facility. Fearing for the infant's survival, the family ultimately left the hospital without formal discharge or transfer papers.

CASE STUDIES

Case Study : 2

(Using pseudonyms to ensure safety, privacy, and confidentiality)

Sumaiya, a 35-year-old Rohingya refugee woman residing in India with her family. She suffers from kidney failure, a condition requiring regular and costly medical treatment. Despite repeated attempts to access care at government hospitals, she was denied treatment as she does not possess an Aadhaar card which is required for accessing most public health services. Private healthcare also remains inaccessible as the expenses are far beyond her financial means.

The family has no source of income, as her husband is unemployed and struggles with alcohol dependency. Sumaiya bears the sole responsibility for sustaining the household and caring for their 10-year-old daughter, who also requires an urgent appendix surgery. Sumaiya expresses deep fear and distress over her daughter's deteriorating health, feeling helpless in the face of medical needs and the absence of financial support.

FINDINGS

Challenges Faced by Refugees with Physical and Cognitive Impairments



Findings: Challenges Faced by Refugees with Physical and Cognitive Impairments

For Rohingya refugees with physical and cognitive impairments the combined effects of persecution, forced displacement and ongoing exclusion create distinct and added forms of vulnerability. Among the 22 respondents, participants reported a range of physical and cognitive impairments. The physical disabilities included **visual impairments, hearing impairments, limb loss and mobility-related disabilities**. Cognitive disabilities included **developmental delays, Down syndrome, and conditions affecting cognitive processing and daily functioning.**

From our observations, we identified a notable number of children displaying developmental delays and stunted growth across multiple settlements, particularly in Hyderabad, Jammu, Mewat and Mathura.

While this research did not assess the causes of these conditions, their repeated presence across geographically distinct settlements points to the need for further investigation into the long-term effects of displacement, deprivation, nutritional insecurity, and barriers to healthcare on both children and mothers.

STUDY DEMOGRAPHICS

N: 22

Age Group: 7-70

Locations:

1. Delhi
2. Hyderabad, Telangana
3. Haryana
4. Jammu, J&K

Findings: Challenges Faced by Refugees with Physical and Cognitive Impairments

The findings of the United Nations Independent International Fact-Finding Mission on Myanmar (2018–2019), which found evidence consistent with genocidal acts against the Rohingya, indicate the long-term harms caused by sustained violence and persecution. Reports and studies[14] on genocide and forced migration has highlighted the "disabling effects" of structural violence, whereby prolonged deprivation, exclusion and denial of access to essential services can contribute to physical impairments, chronic health conditions and psychosocial distress. These historical harms intersect with ongoing barriers they face in India to deepen vulnerability.

All respondents (100%) reported being unable to access treatment at government hospitals due to the absence of required identification documents. As a result, many are left without essential medical treatment, rehabilitation services, assistive devices, or specialist care, worsening existing health conditions and reducing opportunities for independent living.



reported being unable to access treatment at government hospitals due to the absence of required identification documents

report being depended on others to take them to the hospital

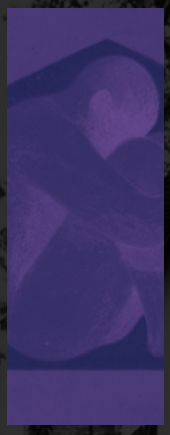
Findings: Challenges Faced by Refugees with Physical and Cognitive Impairments

For respondents with physical impairments, mobility emerged as a major challenge. Many relied entirely on family or community members to travel, including for healthcare appointments, making them highly dependent on others for basic movement and access to services. For respondents with cognitive and developmental impairments, caregivers described the difficulties of providing continuous support in conditions marked by poverty, overcrowding and limited access to specialized services.

Individuals with physical disabilities, as well as those with cognitive and developmental impairments described experiences of stigma and social exclusion related to their disabilities, which negatively affected their dignity and self-worth. A majority (86.4%) reported significant distress and discomfort arising from the combined effects of disability and displacement. The inability to work due to impairments forced some individuals to rely on begging or complete dependence on others, often contributing to feelings of humiliation and helplessness. For those living alone or without stable support networks, these challenges were particularly severe.

Together, these findings suggest that disability among Rohingya refugees cannot be understood solely as an individual health condition. Rather, it is shaped and intensified by the cumulative effects of persecution, forced displacement, social exclusion, and ongoing barriers to healthcare, livelihoods, and community support.

86.4%



reported significant distress and discomfort arising from the combined effects of disability and displacement.

CASE STUDIES

Case Study : 1

(Using pseudonyms to ensure safety, privacy, and confidentiality)

Nur Alam, a 29-year-old Rohingya refugee man residing in India, faces multiple layers of vulnerability stemming from displacement, disability, and poverty. He is physically handicapped with complete immobility in both legs. He has attempted to seek medical treatment twice in government hospitals but was denied care due to the absence of an Aadhaar card. His disability restricts his ability to work, and he manages to earn only ₹200–300 a day through irregular labour, leaving his family in severe financial distress. His 7-year-old daughter, who is also physically disabled, requires medical attention that he is unable to afford. Nur Alam expresses deep anxiety about his daughter's future, particularly her education and health, given his limited means. He also shares feelings of stigma and social exclusion arising from his disability and inability to perform daily tasks independently. These challenges are further intensified by the harsh living conditions within the refugee settlement.

RECOMMENDATIONS

The following recommendations are based on the study findings

RECOMMENDATIONS FOR THE GOVERNMENT OF INDIA

The Government of India should:

- End unlawful deportations of Rohingya refugees and honor the principle of non-refoulement.
- Recognize UNHCR refugee cards for all legal and identity purposes; permitting access in schools, universities, hospitals and for specialized healthcare like mental health services with UNHCR cards.
- Bring the Rohingya refugee population under the ambit of Accredited Social Health Activist (ASHA) workers to access maternal care, immunisation, and community health services.
- Support and fund local NGOs and CSOs to implement community-based mental health support programs, create safe spaces and run workshops and clinics on sexual and gender-based violence (SGBV) and legal aid in Rohingya refugee settlements.
- Stop harassment of NGOs, CSOs and individuals who assist and support Rohingya refugees in a humanitarian way.
- Ensure that all Rohingya refugees in India have access to fair and transparent asylum processes through UNHCR. This includes not refusing exit visas.
- Make the Immigration and Foreigners Act, 2025 favorable for Rohingya refugees to access protection and asylum services; and remove their classification as “illegal migrants”.
- Actively support the Rohingya refugee community on global platforms such as the UN General Assembly and Human Rights Council; and condemn Myanmar military’s treatment of the Rohingya people.

RECOMMENDATIONS FOR UNHCR

UNHCR should:

- Advocate strongly with the Government of India against arbitrary detention and deportation of Rohingya refugees in India.
- Strengthen collaborations with international humanitarian and development organizations, such as IOM, WHO, and local NGOs, to pool resources in addressing the legal, mental, and physical health and nutritional challenges of Rohingya refugees especially for most vulnerable groups such as pregnant women, children, the elderly, and people with disabilities.
- Establish a comprehensive mental health strategy that addresses the trauma and psychological needs of Rohingya refugees, both in the short-term and long-term. Additionally, collaborate with Foundations, Philanthropic organizations and local CSOs for funding and implementation
- Work with the GOI and partner local organizations/CSOs to prioritize funding and support for the most vulnerable and trauma-affected Rohingya refugees; given the cancellation of special allowances for many vulnerable Rohingya refugees because of U.S. funding cuts

RECOMMENDATIONS FOR CIVIL SOCIETY ORGANIZATIONS

Civil Society Organizations (CSOs) should:

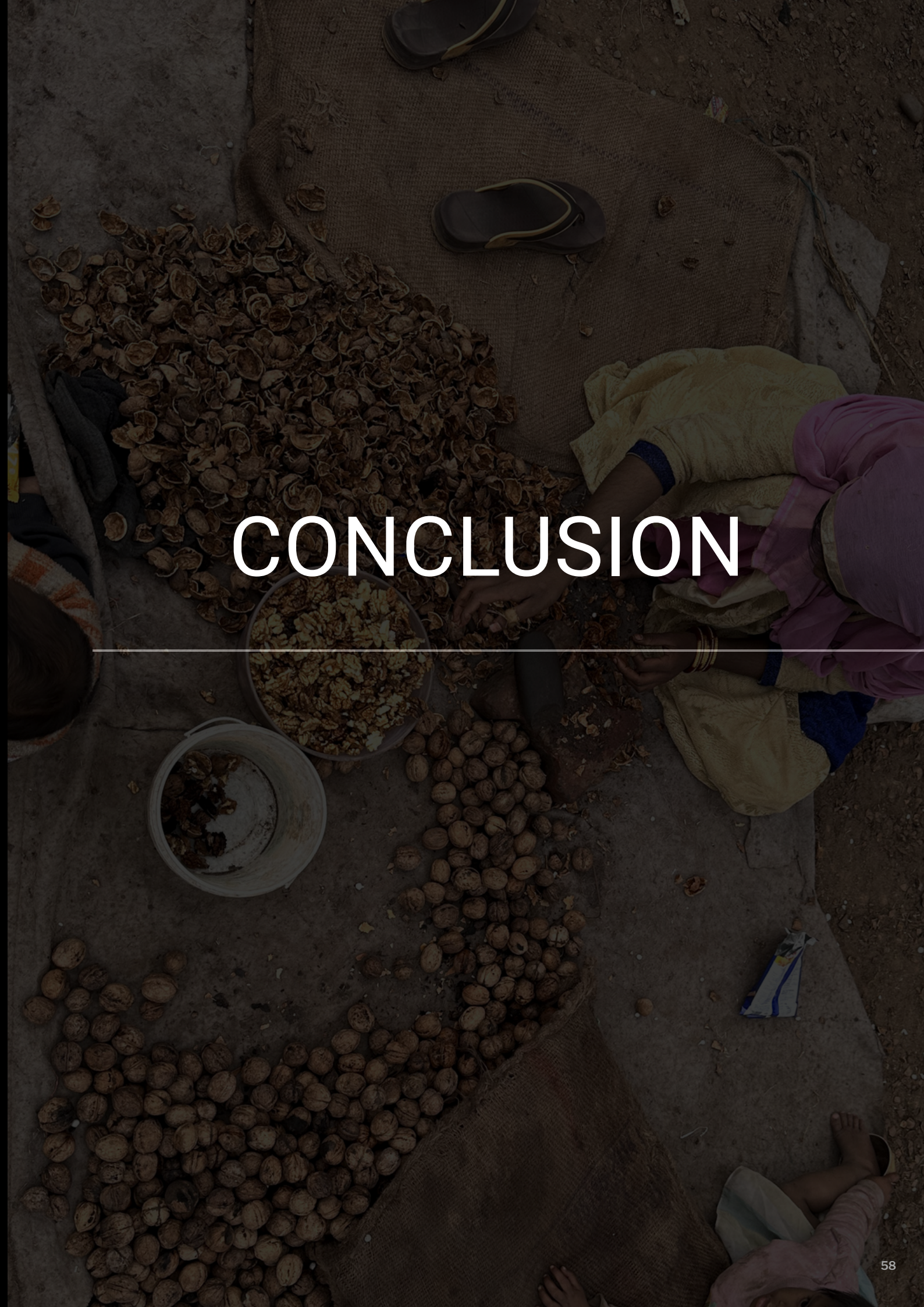
- Work with UNHCR to locally advocate for admission of Rohingya children in institutes and for higher education, and for health service access at no cost or subsidized cost at government health care centers.
- Create community centers that are run and operated by the Rohingya refugees themselves, with CSOs providing support, training, and resources. Run peer-support and community-based mental health programs and empower and train refugees to become mental health advocates.
- Organize frequent legal aid clinics for Rohingya refugees in detention centers and the communities they live in.
- Develop or partner with online platforms offering digital education, language courses and vocational training programs, accessible to refugees on mobile phones or other digital devices. Foster cultural exchange events where Rohingya refugees showcase their heritage through food, music and art to promote inter-community understanding and solidarity.
- Create community centers that are run and operated by the Rohingya refugees themselves, with CSOs providing support, training, and resources. Run peer-support and community-based mental health programs and empower and train refugees to become mental health advocates.

RECOMMENDATIONS FOR INTERNATIONAL OMBUDSMEN

International Ombudsmen should:

- Undertake periodic reviews of India's treatment of Rohingya refugees, focusing on detention practices, legal rights, and health conditions, and publicly report on these findings.

- Highlight the need for urgent resettlement of Rohingya refugees in indefinite detention.



CONCLUSION

Conclusion

In conclusion, the Rohingya refugee crisis in India exposes a persistent failure to uphold the fundamental rights and dignity of one of the world's most vulnerable communities. Mental health distress, inadequate healthcare, climate challenges, systemic exclusion and legal precarity have created a cycle of vulnerability, disproportionately affecting women, children, the elderly, and persons with physical and cognitive impairments. This report demonstrates that immediate, coordinated action is essential. Authorities must ensure legal safeguards for Rohingya refugees, including recognition of UNHCR documentation. Access to public healthcare, especially for chronic medical conditions, including disability-inclusive services, must be granted. Humanitarian organizations can collectively put efforts into supporting and restoring aid to the community, particularly in the wake of aid cuts.

Finally, targeted protection for women and girls against gender-based violence and enhanced support for persons with disabilities are critical to preventing further marginalization. Without urgent and sustained intervention, the Rohingya refugee community will remain stuck in a cycle of neglect and exclusion. Addressing these challenges is not only a humanitarian imperative but a moral and legal obligation, requiring India to align its policies with international refugee protection standards and provide a pathway for dignity and safety.

ENDNOTES

Endnotes

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