The Rohingya in India

Situational Analysis Report

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Note: all names of Rohingya persons in this report are not real names

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List of abbreviations

BPL	Below Poverty Line
FGD	Focus Group Discussion
ICDS	Integrated Child Development Service
INR	The Indian rupee
J&K	Jammu and Kashmir
POC	Persons of Concern
RTE	Right to Education Act (2009)
WaSH	Water, Sanitation and Hygiene

Executive Summary

This Situational Analysis report on the Rohingya community in India deepens our understanding of their lives, issues related to their access to crucial services of water, sanitation, health, women and child development and education. The report documents issues of self-reliance among the Rohingya POCs and compares their livelihoods with those adopted by their Indian neighbours. The life of the POCs is affected by the quality of their relation with their Indian neighbours, which is also assessed and documented in the report.

The report is of immense importance because most households of the Rohingya community are residing outside Delhi in different parts of India that are not served by any NGO. The urban centres and rural areas where the POCs are living lack in access to a great degree. The numbers of the Rohingya asylum seekers and refugees has grown over the past couple of years and is expected to grow faster in the coming years.

The report highlights the mixed and varied nature of the Rohingyas' access to services. Above all, it highlights the confusion among the service providers with regard to eligibility of beneficiaries and requirement of documents. Local support to the community is also varied depending on the overall socio-political conditions of the location.

Key Findings and Recommendations

1. Access to Services

With some variations depending on their location in India, the POCs have highly limited access to crucial services essential for survival. The approach of service providers to allow access to the POCs was also found to vary from location to location and one official to another. Low awareness among community, particularly in the field of health, also causes problems.

It is recommended to advocate and lobby with the service providers to increase access for the members of the community, particularly women, children and the elderly. A clear understanding of the legal and policy framework of the public services will be helpful in this endeavour. The refugees should be made aware of health issues and empowered to access services. Where gaining real access is not possible community health initiatives should be launched that take care of the preventive needs and link the needy persons with secondary and tertiary health care. In the field of education too, the recommendation is to increase access for the children of the community through advocacy and lobbying. Where this is not possible in the immediate future, community initiatives need to be supported.

Women practicing unhygienic methods of sanitation during menstruation have health and mobility consequences to them. Partners should engage with women to find hygienic solutions acceptable to them.

Children working to earn a living for their families are a matter of serious concern. This situation results from lack of access to education, the associated unaffordable expenses and

need for children to augment the earning of adult members of the family. In some families, it is the children who are the main breadwinners.

It is recommended to engage with the community to promote education by taking children out of their work responsibilities. Women should be encouraged to work. Incentives to families who send their children to schools may be considered.

2. Self-reliance

The POCs are engaged in the lowest levels of livelihoods such as rag-picking and unskilled work in the construction industry. They lack language and urban skills needed to access better and wider variety of livelihood options. It is recommended to provide language skills training to the interested POCs in all locations and urban skills training wherever possible and link them up with employers. Home-based solutions for helping women to earn an income need to be found, women trained with skills to benefit from these solutions and they be linked up with suitable local businesses. Wherever possible, women should be encouraged to move out of their homes for work.

3. Rohingya migration and housing

Largest concentration of the community in Jammu receives high number new arrivals. The location poses an additional risk to the safety, security and personal liberty of the POCs due to its sensitive nature and proximity to the border between India and Pakistan. Family/ community networks and better livelihoods attract new arrivals here.

In most locations the POCs are living in clusters on land either rented from or donated by local persons. The clusters and the densely built shanties are partly responsible for unhygienic conditions and also pose potential fire hazards. They also give the community adverse visibility in the location. Another concern is the fewer household possessions of the POCs. They have unhygienic and inadequate number of utensils, water storage cans, bedding and blankets.

It is recommended that support mechanisms in other urban locations such as Hyderabad and Jaipur be developed to strengthen POCs' access to better livelihoods. Such a situation will widen the migration options of new arrivals and the existing population alike. Higher incomes through better livelihoods will also promote them to move into houses with better water and sanitation infrastructures.

Relief in the form of utensils, water storage cans and blankets may be provided to the POCs as a short term measure.

Activities to strengthen cooperation and harmony between the Rohingya community and their Indian neighbours should be initiated.

Introduction

Members of the Rohingya community who have fled to India due to their statelessness in Myanmar, violence and persecutions there have been approaching UNHCR in New Delhi seeking refugee status. By the end of 2013, nearly 4800 Rohingya are registered with the UNHCR, while an additional 2800 have received registration appointments.

Rohingya are mainly living in north and north-western parts of the country such as Jammu (J&K), New Delhi, Mewat (Haryana), Jaipur (Rajasthan) and the South Indian city of Hyderabad. They are also living in the some of the towns like Meerut, Saharanpur and Muzaffarnagar in the western part of the state of Uttar Pradesh.

The present situational analysis report pertains to general information on the Rohingya communities in the major settlements related to demographics, migration patterns, basic shelter, water, sanitation, health and education. The report also maps available public services and issues related to access for the Rohingya community and obstacles faced in accessing the services. It also identifies the coping strategies and self-reliance activities of the Rohingya community and organizations and individuals who are assisting the Rohingyas in different locations. Finally, the report draws a comparison between the situations of Rohingya settlements with that of the neighbouring local communities.

Objectives

i. To obtain general information on Rohingya communities in the major settlements related to, demographics, duration of stay in settlement, reasons to reside in the specific settlement and basic shelter and WaSH conditions;

ii. To map available public services and/or private/civil society organizations in the neighbourhoods/towns of Rohingya settlements, to assess access by Rohinghya communities and obstacles faced in accessing the services;

iii. To identify (other) existing coping strategies and self-reliance activities of the Rohingya communities;

iv. To identify individuals or organizations that could be able and interested to improve/support the Rohingya communities' access to services and/or coping mechanisms and self-reliance;

v. To draw a basic qualitative comparison of the situation of the Rohingya settlements/ groups with that of neighbouring resident or migrant communities.

Data was collected during October 2013 from Rohingya communities in the locations Jammu, Delhi, Mewat (Haryana), Jaipur (Rajasthan) and Hyderabad. Locations in state of Uttar Pradesh were not covered due to communal violence going on there during the period when the data collection was done.

Data collection tools were designed by DAJI and enumerators and field personnel in all locations were provided orientation. Compilation of data and the situational report bringing together diverse reports was also done. The data and draft reports from different locations were discussed in a meeting held in early November.

The Rohingya Refugees in India

The migration of Rohingya refugees into India is about 20 years old. Some of the earliest refugees are settled in Jammu, while the later arrivals have spread to different locations. However barring some differences, the socioeconomic concerns and issues of basic necessities of life are similar in all locations across India. Yousuf, one of the earliest Rohingyas in Jammu said that he was living in the Nizamuddin area of Delhi after migrating to India where he met a Kashmiri person who told him that in J&K he will find better employment and sympathetic people for support. That is when he moved to Jammu and has lived with his family here since the last twelve years. Hyderabad is another location with a large number of Rohingya refugees. Other locations such as Delhi and Jaipur have a smaller number of the Rohingya in urban situations, while those in Mewat are living in rural areas but are mostly engaged in wage labour in the construction industry.

Different locations in India offer different types of situations to the Rohingya in terms of access to services; safety and personal liberty. A large number of the Rohingya are living in Jammu, where the rate of arrival is also high, as it offers better opportunity in terms of diverse livelihood options with better wages. The state of J&K being perceived as a Muslim-majority state in India also seems to affect the migration decisions of the refugees. However, most refugees are living in cluster-type of situations where they rent land from locals and build their shanties in a close-knit setup. A potential security concern for the refugees is the location of J&K, being close to the international border/line-of-control between India and Pakistan. Other locations are relatively safer, however the community networks, relatives and friends who have been living in Jammu attracts new arrivals to migrate there.

Methodology

Following methods were used for gathering data relevant to the situational analysis.

Community Mapping

This exercise was done by members of the community themselves with training inputs given by the data collection personnel. The main objective of this exercise was to gather demographic data of the POCs, whether living in scattered pattern or in clusters. A ‘cluster’ was understood as a group of POC households living in a specific area with some kind of demarcation. The mapping was done in a participatory way with members of the community. Both women and men of different ages participated together. Large sheets of paper and coloured pens were used in this exercise, and individuals with sketching skills from the community were encouraged to lead the exercise.

The main objective of community mapping was to gather demographic data including number of widows, single mothers, elderly persons, disabled persons and unaccompanied/ separated children. The participatory process yielded household-wise demographic data. Other physical aspects of the clusters and areas where the POCs lived were also observed and documented. These included:

- landmark near the cluster and approximate distance of the cluster from the landmark
- GPS coordinates of the cluster

- Physical characteristics of the area where the persons of concern are located (in terms of terrain – plains, hilly, climate, natural water sources etc)
- The kind of dwelling POC's live in (tents, huts, apartments, houses, other)
- Nature of dwellings of the local population
- Fitness of POC dwellings to provide adequate protection from the weather?
- Sewerage system and latrines used persons of concern and how these are built and operated
- Community garbage disposal system and how it operates
- Water supply sufficient and if the community able to maintain basic hygiene

Key Informant Interview

Interviews with key informants in the community were carried out so as to develop an in-depth understanding. The sample of informants from the community was selected using a purposive sampling framework keeping in mind the following should representative variables:

- Gender (an equal number of men and women were interviewed)
- Different age groups (the following categories were set: 18-25, 26-45, 46-65, 65+)
- Year of arrival in India (recent arrivals were also included in the sample)
- Physical location of the cluster (within a larger location such as a city)
- Type of dwelling (rented house, temporary shelter)
- Widows, single mothers and elderly people were included in the sample.

A printed copy of the 'Key Informant Interview Questionnaire' was used for documenting the responses.

Focus Group Discussions (FGDs)

FGDs were held with members of the community to collect relevant data pertaining to the objectives. Focus groups were constituted on the basis of a common identity or sub-identity of the members of the group, such as gender and age. Detailed guidelines were provided to personnel conducting FGDs.

Above methods were used mainly to gather data related to migration, access to services and self-reliance issues of the POCs. Following information relating some of the objectives of the situational analysis was collected wherever possible:

- Available public services
- Information about Indian NGOs working on access to services and skill development issues relevant to the Rohingya in the area/ city of their residence and their willingness to engage with the issues of the POCs
- Attitudes and relations of the Indian neighbour towards the Rohingya

The last method was also used to assess relative poverty among the Indian neighbours of the Rohingyas and difficulties they have in accessing services.

Current Demographic Profile

The areas in and around Jammu city in the state of J&K form the largest population of the Rohingya in India with about 4000 persons, followed by Hyderabad which has a population of about 1300 persons. Other locations such as Delhi, Jaipur and Mewat have fewer than 700 persons. The majority of the Rohingya in different locations are living in camp-like situations, while only a minority of them are living in rented rooms scattered among the local and internal migrant population. A few of the clusters are built on existing slum areas where internal migrants also live. Many individuals and families directly arrive in any of the locations, while a smaller number of them have arrived from other locations in India. A significant number of the refugees in different locations spent months and years in Bangladesh before migrating to India.

There is a significant migration of young girls from Jammu to other places in India for marriage. The large number of families here acts as a 'human bank' for the community in India. Any Rohingya family India wanting to get their son married looks for a bride either in Jammu or back in Myanmar. Once the marriage deal is struck, the bride is relocated the family's settlement where the marriage takes place. Once the couple is married, they may migrate back to Jammu from other locations in India for the man to seek better employment opportunities. However, the majority of marriages take place within Jammu. Few cases of trafficking of young girls out of Jammu are also reported.

TABLE 1 shows the demographic data in different locations. Demography in all locations shows a uniform pattern, where the 45+ population drastically reduces from the age groups preceding it. Children below18 years of age form the bulk of the population, almost 50% in some of the locations, followed by the 18-45 years age group. Children under 5 years constitute about a quarter of the population. This indicates a clear pattern in the migration flow, where it is the majority of men in the working group of 18-45 years that have arrived in India. Most of the elderly are left behind in the country of origin. There are also a few cases of families migrating in phases, where a part of the family comprising of children, men and women in the age group of 10-40 years arrive in the first phase, followed by elderly persons. The population pattern also clearly shows fewer women than men across all locations and age groups. There is an expected number of widows, single women, elderly and unaccompanied minors/separated children. The majority of the households remain in the same location they arrived in India, with fewer refugees migrating within India. There are also reports of a large number of evictions of the refugees who live scattered among the Indian population.

As noted previously, Jammu shows the highest rate of new arrivals. This is on account of family networks, better and diverse livelihood options and sympathetic locals. Hyderabad is the next most sought-after destination.

TABLE 1: demographic data in different locations															
Location	0 – 5 years		Total 0 – 5 (% ages)	6 – 18 years		Total 6 – 18	Total children (under 18)	19 – 45 years		Total 19 – 45 (% ages)	46 – 65 years		65 + years		Total
	Female	Male		Female	Male			Female	Male		Female	Male	Female	Male	
Jammu	389 (10.7)	445 (12.2)	834 (23)	556	622	1178	2012 (32.4)	703	768	1471 (40.4)	35	101	7	9	3635 (59.2)
Hyderabad	167	144	311 (24.2)	126	160	286	597 (46.6)	275	305	580 (45.2)	37	47	12	8	1281 (20.8)
Mewat	58	84	142 (20.1)	111	103	214	356 (52.5)	125	150	275 (40.5)	15	22	4	6	678 (11.0)
Delhi	36	40	76 (24.6)	31	45	76	152 (26)	65	69	134 (43.3)	10	7	4	2	309 (5.0)
Jaipur	32	33	65 (27.6)	27	33	60	125 (53.2)	42	45	87 (37)	6	4	6	7	235 (3.8)
Total	682	746	1428 (23.2)	851	963	1814	3242 (52.8)	1210	1337	2547 (41.5)	103	181	33	32	6138

Total Females: 2879

Total Male: 3259

Note:

1. Figures in parentheses show percentages.
2. Age group percentages are against the total population of the location
3. Percentage of population in a location is against the total in all locations

A senior respondent said that he heard about Hyderabad he and others reached Kolkata. They heard that it is a good place to live in for Muslims and get support from locals. Some of the new arrivals were asked to come to Hyderabad through phone calls. Yet others were brought here from Kolkata by those who had arrived earlier. The POCs in Jaipur go to Delhi to escort the new arrivals to Jaipur.

The reason for the POCs to migrate to a certain location in India is primarily determined by their community networks, economic considerations and other factors. Data-collection done in the five locations clearly identifies the following reasons given by respondents:

- Presence of a relative
- Presence of a relative along with better livelihood opportunities
- Presence of a relative along with better facilities (like access to drinking water)
- Established community
- Lower rent
- Joining family
- Safety and security considerations

Among the vulnerable sections of the population, there are a significant number of widows and single mothers, elderly and disabled. Jammu has the largest number of unaccompanied/ separated children as the TABLE 2 below shows:

TABLE 2: Vulnerable persons in the population										
	Widows/ single mothers	Elderly persons (70+)		Disabled persons					Unaccompanied / separated children	
		M	F	Vision	Speech	Hearing	Limbs	Mental disability	M	F
Jammu	82	57	45	12	3	18	11	5	46	17
Hyderabad	58	31	2	8	5	11	9	0	33	11
Mewat	24	3	4	5	0	0	2	1	0	1
Delhi	14	0	10	5	0	4	3	0	0	0
Jaipur	7	3	7	3	2	6	4	1	2	4
Total	185	94	68	33	10	39	29	7	81	33

Persons with disabilities and the unaccompanied / separated children also form significant part of the vulnerable population.

Shelter-Related Issues

A majority of the POCs in India live in clusters, while a smaller number lives scattered among Indians neighbours. Those who live in clusters have built their own shanties by buying wood and plastic sheets. In Hyderabad, a NGO donated plastic sheets to the POCs for building huts. Those who are living in a scattered manner live along with Indian neighbours in rented low-ceilinged rooms in concrete buildings, with shared water facilities and latrines. Each latrine is usually shared by 25-30 persons living in such establishments. Most of the Rohingya families have just

one room measuring not more than 50 square feet. A POC group in Mewat lives in an abandoned government building. Most clusters in this location are on lands donated by local persons.

A critical access problem for the POCs in most location is the use of burial grounds. Local people are averse to allowing the Rohingya to bury their dead in the existing burial grounds. This is a serious problem particularly in Jammu and Hyderabad.

Landlords of some clusters in Jammu do not allow their tenant refugees to dig pits for latrines. Some groups of families have very small pits requiring new ones to be dug and used when an existing pit is full. Yet others living in dense clusters surrounded by the houses and farms of local residents practice a more unhygienic method. They collect faeces in plastic bags kept at one side of the makeshift latrines and dispose them off in the jungles at night. Most of the dwellings in the clusters are *jhhuggis* (shanties) of one or two rooms built of wooden planks and plastic sheets. The families with better resources have a sitting room, a kitchen and a private room. Latrines and bath spaces are built commonly by 3-4 families in the middle of their houses. Waste water from the latrines and bath spaces flows out in open drains. Children defecate in the open near the houses. Most of the clusters are separated and demarcated from the refugees either by road, boundary of colony, irrigation canal, railway track, an open plot etc.

TABLE 3 below shows the number of clusters and households in different locations:

TABLE 3: clusters and households in different locations					
	No. of clusters	Households living in clusters	Households living scattered	Total households	Total population
Jammu	16	856	73	929	3635
Hyderabad	5	166	188	354	1281
Mewat	6	146	1	147	678
Delhi	1	48	31	79	309
Jaipur	0	0	62	62	235
Total	28	1216	355	1571	6138

Above figures clearly show the pattern of settlement of the Rohingya households in India across most locations. 77.4% of the households live in shanties built by themselves in clusters while 22.6% live scattered among Indian neighbours in rented rooms.

Many families buy fuel wood for cooking but also meet their requirements from the open spaces and jungles. Some exclusively depend on these sources for collecting the firewood. However, they have to face the wrath of local people and the staff of forest department even if they are only collecting dry twigs shed by trees.

The families that live in buildings usually pay rent of INR 1500 – 2000. Non-payment of rent in time is a reason leading to eviction of the family by the house-owners. Mr. Mohammad Elias, one of the refugees in Hyderabad says that he was evicted by the house owners when police came to his house to inquire. Mr. Zoharuddin, who came to Hyderabad from Mewat, Haryana, was abused

and evacuated by the house owner because he could not pay rent. They said that many refugees in Hyderabad have experienced this kind of situation from house owners.

A majority of the households lack adequate number of blankets and bedding. They use cardboard sheets salvaged from the rag and junk they collect to spread on the floor and use as bedding. Lack of utensils for cooking is another major problem. Many families have only one utensil. They manage by first cooking rice which is then put on a piece of paper and *dal* is cooked in the same utensil later. They also lack in adequate number of plates – sometimes 2-3 persons or an entire family eat from the same plate.

Overview of Public Services

Data on public services in the areas of health, ante-natal and post-natal care, early child care and nutrition and education was collected from the locations by interviewing the concerned personnel wherever possible and from internet sources.

Antenatal, Infant and Postpartum Services

These services are available in the field of medical care in the form of immunization and nutritional support under the Integrated Child Development Services (ICDS). Under this service, all the pregnant women, mothers and infants are mandated to be covered, irrespective of their status. However, the scheme suffers from many implementation problems. The Anganwadi centres that implement the scheme are required to give preference to the poor families that are listed under the BPL. However, it does not prevent access to children who are not from BPL families. Evidence of the POC children being admitted to Anganwadis was found in Jaipur.

The Anganwadi centres (http://www.aanganwadi.org/)are mandated to provide the following types services:

- Vaccination and nutritional food (some days dry and other days freshly cooked) for pregnant women, infants and children
- Information about food fit for growing infants and children
- Celebration of birth days of children and taking children for outings
- A bag containing a notebook, pencils and learning progress reports of each child
- Special care and food to children identified suffering from malnutrition (though the centre did not have a weighing machine)

A new program called *Sabala* has now been added to the functions of the Anganwadi centre that takes care of adolescent girls. They are provided with information and training on body growth, managing periods of menstruation. They are given cooked food, given the raw materials and trained to cook the same for themselves. Girls are also taught life and livelihood skills.

However, the ICDS suffers from several shortcomings one of which being misconception among the personnel that only those with some kind of documentation are eligible to access the

services. The service also suffers from lack of adequate personnel, buildings and nutrition supplies. The centres are also overcrowded and it takes a long time for the local administration to open new centres.

Education

Primary school education is provided to all the children in the age group of 6-14 years under the Right To Education Act, 2009 (RTE). Only in the state of J&K a similar Act is yet to be passed by the State Assembly. The law being framed under the Article 21 of the Indian Constitution that guarantees Right to Life, the schools are mandated to admit a child without any conditions. However, the primary education sector suffers from a lot of implementation problems, such as overcrowding, denial of admissions to children without proofs such as birth certificates and residence proofs. Worst being non-implementation of the RTE itself – schools still demand birth certificates and proof of residence from the internal migrants as well. Nonetheless, there is enough space to lobby and advocate with the primary education in the public domain for admissions to the Rohingya children. A school teacher in the neighbourhood of Rohingya refugees in Jaipur said schools are not supposed to require birth certificates but enrol children on the basis of the information given by the parents or guardians of the child.

Health

The third kind of service available to all the people are the primary health services. In some states, the services are better than in others. For instance in Rajasthan, the government provides free medicines of 400 different varieties to all patients. In Jammu also, a small number of women delivered babies at hospitals and also received monetary benefits under the central government's scheme *Janani Suraksha Yojana*. The network of government dispensaries and Primary Health Centres are mandated to provide primary health care facilities to all patients. The types of care provided normally are:

- Infant immunization
- Anti-epidemic care
- Blood and urine examination for various illnesses including, malaria, urinary infections and TB
- Free vaccinations for pregnant women, infants and children
- Pregnancy test and birth control programs
- Emergencies

The government-run primary health service, however, suffers from severe implementation problems including lack of monitoring, accountability and corruption. A result of this this situation is the apathy shown by the personnel to all the poor, particularly the migrants in urban centres.

Current state of Access to Public Services

Water and Sanitation

Access to clean water for drinking and other domestic purposes is highly restricted for most families. Those living in clusters depend either on the goodwill of the local residents to collect water from the taps/ bore-wells in their houses or on mosques in the area. Neither source provides adequate amount of water. Consequently, the POCs are forced to store water in used plastic cans

which are mostly collected through their livelihood as rag-pickers and junk collectors. In some of the slum areas nearer the heart of the city, the refugees depend on hand pumps but the quality of water is compromised, with biological and chemical contamination.

Access to clean drinking water is a problem alike for those living in clusters and in rented rooms. The ones living in clusters get water either from the land-holder, from a nearby house or from a nearby mosque. In Hyderabad, a sympathetic local who has donated land also made provisions for sinking a bore well, which is a source of water for all the POCs. Since the apartments where most POCs live have no facility of storing water in overhead tanks, most refugees collect water at least twice a day from taps in a nearby mosque and store in small utensils and plastic cans. For a few households, dependence is on water supply made by the city corporation; these families suffer an utter lack of adequate quality and quantity of water. A few lucky families collect water from the taps of the house owners.

Both quality and quantity of water have health implication with causes added because of the unhygienic surroundings they live in. Common health problems caused by in adequate water and sanitation are: intestinal diseases like loose motions, dysentery, and hyperacidity and skin rashes. Some families use simple cloth filtration methods when storing water for drinking purposes. Summer months, when the bore-wells of the nearby houses go dry, are the worst periods when skin irritation problems increase.

Women are the worst affected by inadequate quality and quantity of water. They suffer severe skin irritation problems particularly affecting their reproductive health. Several women complained of burning sensation during urination which increases during summer months. The situation is worsened by the practice of using pads made from old cloths for sanitation during menstruation. These cloths are taken from their used and torn personal clothes or are collected through rag picking jobs. Additionally, the source of these pieces of cloth could be the waste oil-soaked cloths dumped by a factory nearby. A majority of women respondents said they disposed the used cloths in open fields but some said they disposed them in the latrine pits. “It is a sin if men see the pads”, they said. They wash these cloths and use them again. Even if washed well, a major disadvantage women reported is that they are not held in place causing wetness all around and resulting skin problems. Those who have tried to use sanitary napkins available in the market complain of high prices – a packet costs INR 36, they said. Women experience a number of health problems due to this practice, they complained of itching, foul smell, burning during urination and excess amounts of urine discharge (polyuria).

In most of the urban locations, municipal sanitation services are nonexistent. In Jaipur, the POCs and their neighbours dump their waste in a common place in the locality which is cleared by the municipal services once in a month.

Access to health services

Refugees reported greater incidence of illness in India than in Burma. The major health problem they faced in Burma was malaria but in India they face a greater number of intestinal and respiratory problems, along with greater incidence of diabetes, TB, jaundice and hypertension.

Snake bites are another significant problem among POCs living in clusters, ending sometimes in death.

Awareness about their health is low among the POCs due to a combination of factors including their migration to a new environment. They lack an understanding that diseases indicate larger public health problems; they lack awareness of symptoms and signs of disease and are not oriented to early detection and treatment of disease. This state of affairs affects women the most, as some simple measures could improve their health conditions.

In Myanmar, the Rohingya used to depend on herbal medicine and home remedies for treatment of illnesses. Many visit *babas* (quacks) who tell them of ghosts causing health problems and they end up paying for these fake medicines. One cause of some of these problems as well as a general decline in immunity is the compromised diet of the refugees in India, which is not only inadequate in quantity, but is often of harmful quality. “We had good food consisting of vegetables, fish and meat every day in Myanmar; whereas here we are forced to often eat discarded vegetable thrown away by the vendors (which are rotten),” the refugees reported.

Some POCs in interviews and FGDs in Jammu reported using self-made herbal medicines. Since they have access to jungles and are familiar with some useful herbs, they extract the same for treating minor illnesses. They also employ home remedies but only when all these prove ineffective do they go to a doctor.

Some POCs that have previously consulted the nearest primary health centre report that the doctors and staff treat them with disrespect and prescribe expensive medicines. In Hyderabad, POCs’ attempts to access health services proved ineffective because the personnel there demanded Indian documents for providing free treatment. As noted previously, the majority go to private quacks for treatment, common across all locations. The quacks do not charge for consultation but only for the medicine they give. In Delhi the refugees access a private charitable hospital and have to travel a distance of five kilo meters to access secondary and tertiary services. Some persons also directly go to pharmacies and buy commonly known medicines for illnesses like coughs, colds, and some types of intestinal and skin problems.

Due to a combination of factors the POCs resist visiting hospitals, viewing this as the last resort. Specific reasons cited for not going to government hospitals were:

- We feel ashamed to go to hospital
- We feel frightened of the hospital
- No one listens in a government hospital
- If one goes there the doctors ask you to get admitted
- One has to pay in a hospital – whether government or private
- Time is wasted in a government hospital
- We don’t know what to do when sick – where to go and who to seek help from

Both women and men report reproductive health problems. Men complain of burning sensation accompanying urination and rashes around genitals, while women experience leucorrhoea, foul

smell during menstruation and excess bleeding. This is further confirmed by the following experience told during the interview of a male respondent in Jammu:

Both I and my wife have experienced health problems. She had white discharge and I had burning during urination. These problems started after her first delivery. We went to the government hospital and took the prescribed medicine but that made no difference. It was a waste of time going to the government hospital because of the time it took to see the doctor. Though they gave some medicine some other medicine was to be bought. The doctor won't even check us but write the medicine simply on the basis of what we told him. If we asked him what was the problem he would say, "Take this medicine you will be alright." So we went to a private doctor who charges Rs 100 per consultation. His medicine worked and we are both fine now.

Though the hospital staff we interviewed in Jammu was found to be neutral to the POCs' status of being non-citizens, general apathy of the staff towards the poor was found to be the main cause of ill-treatment of the Rohingya. This has been highlighted and reinstated by many cases of child delivery at the hospital as well as cases of severe illness and consequent treatment. Poverty among the POCs emerges as the primary obstacle in accessing key services of the hospital. A majority of the neighbours of the POCs, particularly the internal migrants, also face similar challenges in accessing hospital services.

In an interview the head of an urban health centre said that treatment is given equally to locals and refugees. They did not need any documents. If they have refugee card it is better and even if they do not have there will not be any problem in giving treatment to refugees.

Access to Pre- and Ante-natal Care, Early Child Care and Nutrition

Child delivery generally takes place at home assisted by midwives. The primary reason for a majority of women opting for the traditional method is that it is inexpensive as compared to a delivery at a hospital. Delivery at hospital is considered inconvenient because of the requirement of an attendant for the patient, which is difficult for them being daily wagers. There are other reasons (mentioned below), some stemming from traditional beliefs, which prevent the Rohingya from accessing formal medical services for childbirth. One major cultural reason is that women consider giving birth at home as moral, as it is the traditional way – women that visit hospitals for delivery are generally considered 'immoral'.

The following reasons were given for not opting to deliver babies at hospitals:

- We go to hospital for delivery only if complications arise
- Men disapprove of women going to hospitals
- It is undignified to go to a hospital for delivery
- Only shameless women deliver babies at hospitals
- It is a pious act to deliver at home

Participants in data collection also reported deaths of infants or mothers or birth of stillborn babies. Out of 16 men and women interviewees in Jammu, 12 reported deaths of babies/ mothers/ birth of still babies. In Jaipur, two cases of complications in childbirth were reported. Gul Bahar died 42 days after delivering a child, the community members suspect that she had

breathing problems however the cause remains unknown. While Noor Mohammad's wife Hasina fell ill after delivery and the child died. This indicates a very high level of infant and mother mortality among the community. Deaths of children under the age of 5 due to extreme temperatures, low birth weights and pre-mature births are also reported. Some deaths occurred due to snake bites. Despite this, the POCs still prefer not visiting hospitals.

Leucorrhoea and excess flow during menstruation are the common problems faced by most women of the community. Though some said there is taboo against birth control measures, several women in Jaipur reported using copper-T (IUD-intrauterine device). These women face even more problems such as blood in stools, back pain, excess bleeding etc.

In Jaipur, the community is being visited by the Anganwadi workers and the local government nurse. Most report having received all the vaccinations for themselves and their children in addition to the nutritional supplement and cards. But the filled up cards were never given to them; the nurse kept the cards with herself. One Rohingya child in this location was found attending the Anganwadi centre. The worker said more of the refugee children were admitted earlier but the parents took them away after they learnt Hindi and got them admitted to private schools.

In other locations the POCs are not aware of any Anganwadi centre near their dwellings. Meanwhile, there is no evidence of efforts by the personnel of the centre to reach out to the POCs. Thus, there is a complete absence of public services for pregnant women, infants and children in the areas of health, child care and early education. Women visit hospitals only as the last resort during pregnancy and for vaccinations for the infants. Polio vaccination is the only one most infants have received.

Deliveries at home are assisted by the mid-wives. But there are few mid-wives in the community itself and they charge a fee to attend to births. Therefore several women deliver without the help of a mid-wife. Some families hire the services of a mid-wife from the Indian community but they charge a fee more than the mid-wives among the refugee community.

Access to Education

Rohingyas consider education a key issue for their present and future but are unhappy about the current state of affairs on this front. Education of children is the worst casualty of their migration and refuge in India. Government schools demand birth certificates which none of them have. Even the children who are born at home do not have birth certificates; though it is possible to get birth certificates even if children are born at home, the POCs complain of high amount of bribes demanded by the concerned officials. Only those few who are born at a hospital get birth certificates.

Only two children of the community in Jaipur were found to be studying in the local government primary school. Refugees in general have problem in sending children to government schools both on account of the schools requiring a birth certificate as well they being required to contribute to family income. Many send their children to private schools. In Mewat, a government teacher is providing informal education to the refugee children and also including them in the mid-day meal program of the school.

Except in Jaipur, none of the POC children were found admitted to Anganwadi centres. Refugee children were not admitted to the centres in Hyderabad because the personnel demanded Indian documents such as ration cards from parents. A majority of children between the ages of 6 – 16 contribute to family income by rag picking. Men said in an FGD that it is difficult to take children away from rag picking work and send them to school. “Their families would go hungry if they did that’ was the collective response. ‘They can spend about 2-3 hours a day for learning or playing if there are good facilities.’

In Jammu, the Sakhawat centre of Iqbal Memorial Trust, a local NGO, has been running kindergarten schools near the cluster exclusively for the Rohingya children. The organisation now runs four schools; they have also helped the community in getting children who pass out from their schools to get admissions to government primary schools. They had to get court affidavits as a replacement for birth certificates to be submitted for admissions. A good number of children are either not going to schools or engaged in rag- picking. Sakhawat centre also advocates with the community to stop the practice of sending children for rag-picking. However, the community is forced to do this especially because the men do not earn enough to support the family and women are not supposed to go out and work. With some lobbying by COVA in Hyderabad it has been possible for refugee children to be admitted to government schools.

Livelihoods and self-reliance

Two of the common livelihoods opted by POCs in all locations are rag picking and unskilled construction labour. In Jammu, the Rohingya are engaged in diverse livelihoods, such as sanitation work at railway stations, walnut processing and working in factories and markets as daily wagers. In Jaipur, Rohingyas are also engaged in rickshaw pulling, and unskilled work at markets such as head loading, washing and cooking at road-side hotels. A few work in a nearby ball-bearing factory. Unskilled labour in all the locations generally earns them monthly incomes between INR 3000 – 5000. A few among them in Jammu also run their own grocery shops and fish business where most of the customers are Rohingyas. Except for a couple of types mentioned above, other types of jobs are found through a contractor who deducts his own commission. “It is difficult to find a job on our own; one gets a job only if the contractor trusts you.” A road-building contractor in Jammu has taken about 70 Rohingya workers with him to the neighbouring state of Himachal Pradesh. In Delhi most POC men are working as rag-pickers. A significant number of the POCs in Jammu, including women, are working in a pencil factory.

Common across the different locations, familiarity with local language plays a major role in the kind of work men get. For instance, Kadir Hussain in Jaipur was doing dish washing at a local hotel for one year after his arrival. Once he was familiar and comfortable with Hindi, his hotel owner gave him the cooking job which fetched him an additional Rs. 1000. A respondent who has arrived in Jaipur recently and cannot speak Hindi said he is unable to find a job and would like to go back to Bangladesh, where he lived earlier. In Hyderabad, too, all refuges are daily labourers and language has a significant impact on work prospects. The Rohingyas go to labour marker, waiting for employers to pick them up – however, they don’t get work every day, particularly those who are unfamiliar with the local language. Those who get work earn INR 350 in a day.

Around 800 unskilled persons in Jammu are working as daily wagers as per availability in the market. This unorganized work is highly irregular, and thus the income for daily wagers is not fixed as in other employment areas. Around 200 persons are engaged in sanitation work at the Jammu railway station, where they primarily work as sweepers. Here, they earn INR. 4500/- per month and the timings are not as rigid as factory and construction work. Around 200 persons are working primarily in the industrial area of Bari Brahamana near Jammu. A majority of the workers reside in the vicinity of the factories. Some of the workers also commute from Jammu clusters and areas in the city to these factories. A bus arranged by the management for the workers takes them to the factories. Uniquely, women are also engaged in factory work – around 50-60 women from the vicinity are working in the factories and a significant number of them joins from the city as well. Most Rohingya workers are engaged in the pencil factories and in those units which are not preferred by the locals and internal migrants, both in terms of wages and kind of work.

A few POCs have their own food/ grocery store in Jammu. These shops are mostly dependent upon the Rohingya customers but in few cases, some of the entrepreneurs have also been successful among the locals. The shops are mostly retail household items, while some sell dried fish for the consumption of the Rohingya. The daily turnover of the biggest Rohingya-owned shop that also attracts Indian customers is reported to be around INR 15,000.

Rag-picking is an important livelihood in which a significant number of children are also involved to support their families. According to an estimate given by respondents and by the cluster leaders, around 160 to 180 children are working as rag-pickers in Jammu. The engagement of children in rag-picking is concentrated heavily in the clusters falling within the city. Clusters in the semi-urban areas and in the industrial complex of Bari Brahmana (which is out of municipal limits) have few rag-picker children. The reasons for a large number of children working are primarily poverty, demand for rags and junk and inaccessibility of schools.

Another important source of income for women in Jammu is walnut processing. Walnut processing in Bathindi area of Jammu is one of the major sources of employment for women from the surrounding refugee clusters primarily from Karyani Talab, Rajiv Nagar and Kargil colony clusters. Around 50-60 women are engaged in this work and on average earn around INR 60-70 per day. However, this work is seasonal in its nature and provides employment opportunity for six months of every year.

In general across locations, however, women are discouraged from going out to work. The reasons cited for this by men are: our traditions and religion forbid women from going out for work; she has to take care of children and elders. The perceived threat to women by strange men is also a reason for men forbidding women from going out to work. Women perceive themselves as unable to deal with money and strangers. Some reasons commonly offered by women were: “We don’t know counting beyond 100 – so we will be cheated if we go out to work” and “only the women who are shameless work outside their homes.” Only a couple of women in different locations have sewing machines and they do tailoring for the members of their own community. As noted before, women engaged in factory work is unique to Jammu. In the Bari Brahmana area on the outskirts of Jammu, where a significant number of women work in a factory, Kobir Hussain – whose wife

Salima Bano is engaged in factory work – agreed that culturally men are seen as the breadwinners of the family and women are homemakers. However, he said, "our *watan* (country) has changed and our situation has changed, so we also need to change."

In Hyderabad, Rohingya women do not work outside. They are not allowed by their customs and traditions. They remain at homes and do household work. However, Siasat Organization started learning centres at Babanagar and Shaheen Nagar and giving training in tailoring and embroidery for the betterment of Rohingya women. 60 women at Babanagar and 40 women in Shaheen Nagar are enrolled in these learning centres. In Jammu, the Sakhawat centre has trained a few women in tailoring and has also donated sewing machines to them. In one of the clusters in Mewat women are working as agricultural labourers in the farms owned by the locals.

A number of migrant men among the Indian neighbours of the refugees do the same kind of odd jobs as the Rohingya, but they have slightly higher earnings. In Jaipur, for instance, many collect old newspapers and other kind of junk and are able afford better houses with rents ranging from INR 2500 – 4000. A number of men among the internal migrants in Jammu are engaged in semi-skilled daily wage work, such as masons, electricians and plumbers, in which they earn around INR 8000 – 10000. Among Indian neighbours of the POCs across locations, few women go out to work. Those who do jobs are working as domestic workers and cooks; the younger women are doing jobs in shops and small businesses. The situation in Jammu is unique for women, as they are engaged in diverse livelihood options.

Relations with Indian Neighbours

The relations between the refugees and their Indian neighbours are mixed in nature across all locations. POCs feel the locals look upon the Rohingya with suspicion – consequently the latter keep aloof from their Indian neighbours. One respondent even said that the Indians practice 'untouchability' against the Rohingya. However, some others reported that they were helped by the local Indians. Nussafa was given a sewing machine by the local Indians to earn a living for herself; she was also given food in the initial days of her arrival here. Her son was married in India and the *Nikahanama* was performed by a local *maulvi.*

In Hyderabad, some locals complained that Rohingyas do not live peacefully – they are always quarrelling and have conflicts among themselves. While the locals don't hold negative attitudes towards the Rohingya, they would prefer to help Indian poor in their neighbourhoods than the Rohingya community. Most of the clusters are built on land donated by locals who also got bore-wells dug to provide water to the POCs. In Mewat, the locals not only gave land to the refugees, but also materials to their huts and electric connections.

Young men resented the fact that they cannot freely stand on the street corners and talk among themselves. "The locals scold us if we do that," they said during an FGD. A 7 year old Indian girl told us that she and her friends don't like to play with the Rohingya children because they "keep themselves dirty."

Locals from both Hindu and Muslim community are sympathetic to the Rohingya. They have heard the Rohingya stories of violence the latter have been subjected to in Myanmar. They converse sometimes with the POCs who understand and speak Hindi but language among the Indian and POC women is a barrier to communication and building relations.

In Jammu, the local residents are divided along ethnic lines particularly in the semi-rural localities of Bathindi and Narwal. These communities are the local Gujjar Muslims and the migrant Kashmiri Muslims. There are also smaller communities of migrants – both Hindus and Muslims – from nearer districts. It appears that the Gujjar Muslims (even though some of them have given land to the refugees on rent to build their huts) resent the presence of the Rohingya while the Kashmiri Muslims are sympathetic. The former community also resents the presence of Kashmiri Muslims that are rich and have built houses in Jammu to live in the winter. The different attitudes towards the Rohingya by the local residents on ethnic lines could be for the political reasons of each local community.

According to local observers this alignment of the Rohingya with the Kashmiri Muslims may lead to conflict with the Gujjar Muslims. The refugees may get caught in the confrontation between these two communities.

Potential for Partnerships

As is clear from the above, the services provided by the government are presently inefficient and fall short of requirement. There is also confusion among the service providers regarding the required documents for access. An independent agency could be in a position to activate these services and provide relief to the POCs as well as assist in other ways.

For the time being, Sakhawat centre is the only organisation extending their support to the Rohingya in Jammu, particularly in the field of pre-primary education. Additionally, the centre has helped the Rohingya in obtaining affidavit for their birth certification which is necessary for admission to government schools. The organisation has also trained women in using sewing machines and has gifted some of them with machines.

In Hyderabad, several organizations are already involved in helping the Rohingyas in different ways. In Jaipur, an organization that works with children is interested in exploring possibilities of including the Rohingya children in their programs. However, the organization lacks in understanding of refugee situations.

Conclusions and Recommendations

Though the Rohingya presence in India is 20 years old, a vast majority have arrived after 2008. This is the same time around which they started approaching the UNHCR in New Delhi. In Jammu, the largest settlement sheltering about 4000 persons at present is estimated to receive about 50 families on average in a month. Other places, too, receive new arrivals in proportion to the size of the population at present. A large majority of the refugees live on in the same place where they arrived directly from Myanmar. However, there is evidence that a small number of

them have moved from one place to another within India in search of safety, security, stronger community networks and better livelihoods. Girls are migrating for marriage.

A majority of the POCs are living in self-built shanties on land either rented or donated by sympathetic locals. Their shanties are usually made from wooden planks and plastic sheets. In such places, the huts are built in a dense manner, compromising on hygiene. A small proportion of the community lives in rented rooms among Indian neighbours in all. In the clusters, they build their own latrines, which are used mostly by women and the elderly. Wherever they have access to nearby open fields, they are resorting to open defecation. Those who live in a scattered manner, on the other hand, share latrines with their Indian neighbours. In both types of situations, a toilet is usually shared by 25-30 persons. Some of the Indian poor in scattered locations live in the same type of rooms, share latrines and opt for the same livelihoods as the POCs. However, some others live in better houses – they have greater number of rooms along with access to private latrines. Municipal sanitation services are nonexistent across locations. All women use cloth pieces of their own or those collected through rag-picking during menstruation.

Individuals and organizations from the local community are helping the Rohingya in most of the places. However, the help they provide is limited to certain needs of the POCs. An organization in Jammu is helping the Roingya community by increasing their access to early education. While in Hyderabad, a number of organizations are helping the community through different kinds of donations to meet their shelter, medicines, clothing and food requirements.

The Rohingya have adopted diverse ways of coping with life in India. Deficiency of food intake is a serious crisis they face. They are coping with this crisis by reducing their meat and fish intake. In their country of origin, they had access to meat and fish on a daily basis. In different locations across India, most of them have meat and fish only once in a month. They also collect vegetables discarded in the vegetable market to eat, which are usually defected in some way or rotten. They are meeting their fuel requirements by collecting wood from nearby jungles and open shrubs. The community in Jaipur also uses oil-soaked cloth pieces discarded by nearby factories as fuel. Most of them are earning a livelihood by working at the lowest rung of employment, namely rag-picking and unskilled construction labour, which is common across locations. They are finding these jobs through the members of their community as well as their Indian neighbours. A number of them have learned the local language for better employment prospects. Some of the poorer Indian neighbours adopt the same livelihoods as the POCs, yet others are working in slightly better livelihoods and earning higher incomes, as noted previously.

Specific conclusions and recommendations are as below:

Conclusions	Recommendations
Demography, Migration and Shelter	
A majority of the Rohingya are living in urban and rural areas outside Delhi where they lack access to minimum supports necessary for survival	NGO programs should be extended to the locations where the Rohingya are living.
A majority of the POCs in most locations live in camp-like situations where there is little scope to	Refugees should be promoted to live in rented rooms among their Indian neighbours.

improve sanitation and hygiene. Moreover, the shanties in these clusters densely built together from wooden planks and plastic sheets pose a potential fire hazard. The cluster type of settlements also attract the adverse attention of authorities and others.	
A large number of POCs live in Jammu and the rate of new arrivals is also high here. Reasons for new arrivals coming here are mainly community networks and better livelihood options. The location poses threat to the safety and security of the POCs.	On a long term planning basis other locations, particularly the urban centres, of Rohingya concentration should have adequate response mechanisms to increase POCs' access to livelihoods leading to self-reliance so that theses destinations also become attractive to the new arrivals.
Household Items	
The POC households lack adequate quantity of utensils, bedding, blankets and warm clothing	UNCHR may consider providing the POCs with the items necessary for living as a short measure.
Water and Sanitation	
Most POCs in all the locations have insufficient and irregular access to water and they also lack clean and sufficient ways of storing water	UNCHR may consider providing hygienic water storage canisters and water filters to the POCs as a short term solution.
Health	
Health awareness among the POCs is low. Their understanding of health matters is informed by traditional knowledge. They lack an understanding of the health problems, preventive measures and methods of treatment in new circumstances	NGOs should initiate health education programs
Members of the POC community suffer from anxiety and other health problems due to uncertainty of their lives in India	Partners may consider initiating activities to orient the POCs, particularly new arrivals, to the realities of life in India and the legal processes they have to go through.
Access to Health Services	
Quality and efficiency of health services and access to the poor in India varies from location to location. Rural areas in general are poorly administered as far as health services are concerned. Services in the state of J&K are also poor.	Wherever possible the partners should strive to increase the access of POCs to public health services. Private and charitable services can supplement the service needs of the POCs. Whe both are difficult the partners should consider initiating community health service that takes ca of preventive needs and links up the needy persons with services in the secondary and tertia sector.
Women use old clothes for sanitation purpose during menstruation. This practice causes serious health, work and mobility problems for women	Partners should engage with women among the POCs in health dialogues and explore alternatives to the current practices.
There is confusion about eligibility issues among the service providers in the field of crucial services like health, early child care and education that leads to exclusion of the refugees.	NGOs working with refugees should engage a senior legal professional/ a team to develop a no with a Right to Life perspective on the legal and policy framework of these public services. The same should be used to advocate access in

	different locations for the refugees.
Pre-natal and Post-partum Health and Nutrition services	
There is an absence of access to child development programs. Only in Jaipur some evidence was found with significant access for POC women, mothers and children to the Anganwadi centres that meet the needs in this sector	Wherever possible partners should lobby with the services for inclusion of POCs in these services. Where this is not possible partners may consider establishing counselling services for pregnant women and mothers.
The community depends largely on their own traditional mid-wives for assistance during births. However it is not clear how suitable is the assistance to save the lives of women and children.	Partners initiate a documentation and research exercise into the practices of the mid-wives and assess their training needs. Providing training to the mid-wives may be considered as a next step.
High numbers of infant deaths are reported in the community.	Efforts should be made to link up the POCs with pre-natal and post-partum health and nutrition public services Low cost solutions for preventing infant deaths may be explored. Use of low cost incubators may reduce the infant mortality in the community.
Education	
POCs access to early child care and education (Anganwadis) services is minimal in locations and totally absent in others.	Wherever possible the children in the age of 3-6 years should be admitted to the Anganwadis so that their early education takes place along with the children of their neighbours. Where this is not possible partners may consider establishin[g] early child care and education services as a short term measure.
POC children in most locations do not have access to government primary schools on account of their own perceptions and demands by the authorities for documents	The Right to Education, Act, 2009 is applicable throughout India (except J&K) as per which no child can be deprived of admission to a primary school. Partners should lobby with government schools for admission of POC children. Private and charitable schools may also be explored
POCs have no access to informal/ adult education	Partners may consider linking up POCs with such services by NGOs or providing informal/ adult education directly
A significant number of children are working to support their families	Members of such families should be provided with skills training and livelihood options on the condition that children will be sent to schools. Other incentives may also be considered to promote education
Self-reliance	
Due to poor language and work skills in urban environment, the POC men have access to the lowest wage livelihoods.	Partners may consider initiating language and urban skills training and placement services to the POCs
A majority of women are not contributing to their family incomes	Partners should explore home based self-relianc[e] activities that women can do and link them up with sources of home-based employment.

	Wherever possible women should be promoted to move out of their houses and work alongside the men.
Relations of POCs with their Indian neighbours	
In all places the response of the local people to the POCs is mixed. In Jammu they face a situation where responses are aligned along ethnic lines	Partners may consider initiating activities to bridge information and understanding gaps between the POCs and the local people. Activities to orient POCs to their life in India should also educate them about their relations with their neighbours and how that will affect the prospect of their safety and security.

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