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'Our bodies are the only things left to us': Social exclusion, survival strategies
and childbirth in Rohingya refugee camps of Bangladesh

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Abstract

“Now we need your hands, not your voices” says Fatima, a Rohingya birth attendant who encourages with her words a group of Rohingya women to assist a pregnant woman in giving birth in her shelter in a refugee camp. In a humanitarian context where women’s point of view often remains marginal, the persistence and sense of mutual support of Rohingyas constitute important aspects of their ability to create life. This thesis contributes to the study of Rohingyas living in a context where their citizenship has been denied to them, basic refugee rights are not respected, and they are confined in a condition of protracted displacement in refugee camps of southeastern Bangladesh. Rohingyas have forcefully migrated in masses (1948, 1959, 1978, 1991, 1992, 2012, 2016 and 2017). The present research contributes to the understanding of broader dynamics of social exclusion by focusing on childbirth in three refugee camps, as well as on Rohingya women’s perspectives on reproductive health.

The aim of this thesis is to explore the tension between social exclusion and the persistence of refugees by examining hospitalised and home births, as well as the perspectives of birth attendants. This doctoral thesis is based on my ethnographic research materials collected in 2022 on the life of Rohingyas in three refugee camps in Cox’s Bazar district, Chittagong Division, in southeastern Bangladesh. Based on historical and legal analysis of the Rohingya forced migration to Bangladesh, it aims to examine the various answers that Rohingya women give to the reproductive health system, which is embedded in the “Rohingya humanitarian response”. To live in the camps, Rohingyas have to follow some rules to access humanitarian resources. One of these rules is to give birth in the appropriate health facilities of the camps to have their newborns registered. Instead, in case of home deliveries, Rohingya newborns are not registered under a birth certificate and hence deprived of basic services. Birth certificates are the minimum guarantee for stateless people in a world of nation-states, but some Rohingya women still choose to give birth at home.

The primary health centre in the first camp (informal settlement camp) has taken steps forward to support Rohingya pregnant women, employing two Rohingya birth attendants. Their presence encourages women to attend the health facility. Because camp life weakens Rohingya women’s bodies, they have no choice, but to give birth in the health facility. Women in this camp make a “forced choice” when giving birth in the primary health centre. In the second camp (new camp), the hospital has employed Rohingyas mainly as community health workers, whose task is to convince pregnant women to attend health

facilities. Pregnant Rohingyas prefer home births with a *dhoroni*, “birth attendant”, as these community health workers are not allowed to assist women in the delivery room. In this scenario, they activate various “survival strategies” to give birth in their shelters. In the third camp (old camp), facility-based births have occurred more regularly for a decade. Rohingyas can be accompanied by *dhoroni* and, in this way, they both avoid Bangladeshi midwives and obtain a birth certificate for their babies. Hence, they have “adapted” to camp life.

This study contributes to the anthropology of migration, anthropology of birth and to legal anthropology. The importance of this study is grounded in the necessity to systematically collect ethnographic material on Rohingyas’ camp life, and to contribute to the study of social exclusion and persistence among these refugees. This study also fills a research gap about the knowledge of Rohingya birth attendants, as well as on home births and the hospitalisation of births in a humanitarian context of refugee camps in the geographical Global South. Systematically examining the answers of women who are persistent in facing their everyday challenges is a valuable resource for other non-citizens who could find themselves in similar situations of displacement. Refugees are extremely adaptable, they can cope with the most challenging situations and are creative in finding solutions.

Abstract (German)

„Jetzt brauchen wir eure Hände, nicht eure Stimmen“, sagt Fatima, eine Rohingya „birth attendant“, die mit ihren Worten eine Gruppe von Rohingya-Frauen dazu ermutigt, sie eine schwangere Frau während ihrer Hausgeburt in einem Flüchtlingscamp zu unterstützen. In einem humanitären Kontext, in dem die Perspektive von Frauen oft marginalisiert wird, stellen ihre Beharrlichkeit und gegenseitige Unterstützung ein wichtiges Beispiel für die Fähigkeit dar, mit welcher Geflüchtete ihr Leben gestalten. Diese Dissertation leistet einen Beitrag zur Erforschung jener Rohingyas, die in einem Kontext leben, in dem ihre Staatsbürgerschaft in Abrede gestellt wird, grundsätzliche Flüchtlingsrechte nicht respektiert werden, und die einer dauerhaften Vertreibung in Flüchtlingslagern im Südosten Bangladeschs ausgesetzt sind. Rohingya-Massenmigrationen haben in den Jahren 1948, 1959, 1978, 1991, 1992, 2012, 2016 und 2017 stattgefunden. Diese Forschung trägt dazu bei, um die umfassende Dynamik sozialer Ausgrenzung sowohl durch den Fokus auf Geburt in drei Flüchtlingslagern, als auch durch die Perspektive auf reproduktive Gesundheit von Rohingya-Frauen, zu verstehen.

Ziel dieser Dissertation ist es, die Spannung zwischen der sozialen Ausgrenzung und der Beharrlichkeit Geflüchteter anhand der Untersuchung von Krankenhaus- und Hausgeburten und der Perspektive der „birth attendants“ zu erkunden. Darüber hinaus liefert diese Forschung ethnographisches Material über das Leben der Rohingyas in drei Flüchtlingslagern in Cox's Bazar District, Chittagong Division, in Südost-Bangladesch. Die vorliegende Dissertation beabsichtigt daher - basierend auf historischen und rechtlichen Analysen über die Zwangsmigration der Rohingyas nach Bangladesch -, die verschiedenen Umgangsweisen der Rohingya-Frauen mit dem Gesundheitssystem zu untersuchen, das in die „Rohingya humanitarian response“-Agenda eingebettet ist. In den Camps zu leben bedeutet für Rohingyas, dass sie bestimmten Regeln folgen müssen, um Zugang zu den humanitären Ressourcen zu bekommen. Eine dieser Regeln verlangt, dass Rohingya-Frauen in den entsprechenden sanitären Einrichtungen der Camps entbinden. Anders als jene, die eine sanitäre Einrichtung in Anspruch nehmen, bekommen Rohingya-Neugeborene im Falle einer Hausgeburt keine Geburtsurkunde und in weiterer Folge auch keinen Zugang zu humanitären Ressourcen. Geburtsurkunden sind die minimale Versicherung für staatenlose Menschen in einer Welt, die aus Nationen besteht, und dennoch entscheiden sich einige Rohingya-Frauen dafür, zu Hause zu entbinden.

Das „primary health centre“ im ersten Camp („informal settlement camp“) hat bei der Unterstützung schwangerer Rohingya-Frauen insofern Fortschritte gemacht, als es zwei

„Rohingya-birth attendants“ angestellt hat. Ihre Anwesenheit erleichtert es Frauen, diese sanitäre Einrichtung zu besuchen. Weil das „camp life“ die Körper der Rohingya-Frauen zusätzlich schwächt, bleibt dennoch vielen nichts anderes übrig als in einem Gesundheitszentrum zu entbinden („forced choice“). Das Krankenhaus im zweiten Camp („new camp“) hat Rohingyas hauptsächlich als „community health workers“ angestellt, deren Aufgabe es ist, schwangere Frauen davon zu überzeugen, die sanitären Einrichtungen aufzusuchen. Weil es den „community health workers“ jedoch nicht erlaubt ist, den Frauen in den Krankenhäusern zu helfen, bevorzugen Schwangere Rohingyas daher eine Hausgeburt mit einer *dhoroni*, „birth attendant“. In solch einem Fall entwickeln Rohingya-Frauen verschiedene „survival strategies“, um zuhause entbinden zu können. Im dritten Camp („old camp“) haben die Spitalsgeburten in den letzten zehn Jahren regelmäßiger stattgefunden. Hier können Rohingyas von einer *dhoroni* begleitet werden - auf diese Weise können sie die Interaktion mit Bangladeschi-Hebammen weitgehend vermeiden und gleichzeitig eine Geburtsurkunde für ihre Neugeborenen erhalten. In diesem Fall kann man von einer Anpassung an das „camp life“ sprechen („adaptation“).

Diese Arbeit liefert einen Beitrag zur Migrationsanthropologie, Geburtsanthropologie und Rechtsanthropologie. Die Bedeutung dieser Forschung ist in der Notwendigkeit begründet, mehr ethnographisches Material über das „camp life“ der Rohingyas zu sammeln und einen Beitrag zur Forschung über soziale Ausgrenzung und Widerstandsfähigkeit von Geflüchteten zu leisten. Diese Arbeit füllt eine Forschungslücke über das Wissen der Rohingya-„birth attendants“, sowie über Hausgeburten und die Hospitalisierung von Geburten in den Camps. Systematisch die Umgangsweisen von Frauen zu erforschen, die in der Konfrontation mit den tagtäglichen Herausforderungen widerstandsfähig bleiben, ist eine wichtige Ressource für andere „Nicht-Staatsbürger*innen“, die sich in ähnlichen Situationen von Vertreibung befinden. Geflüchtete sind äußerst anpassungsfähig, sie können sehr herausfordernde Situationen bewältigen und sind kreativ darin, neue Lösungen zu finden.

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Preliminary Notes

The names of the research participants have been changed to maintain their anonymity. I conducted my fieldwork in three refugee camps. The names of the camps have been changed to prevent the tracking of the information analysed in the present work and to protect the confidentiality of the research participants.

Bangladeshi, English, and Rohingya are the main languages used during my fieldwork. As for their spelling, I refer to the Rohingya spelling according to the *English-Rohingya Dictionary* by E.M. Siddique Basu (Siddique Basu, 2018) as it is the only Rohingya dictionary I have. Nevertheless, this dictionary is limited as it does not include words that I have learned during my fieldwork. These limits are due to differences that correspond to the various local dialects among Rohingyas, and the main linguistic differences in Rakhine State regard pronunciation. One of my language teachers continued to support the drafting of this work, and I am profoundly grateful for his assistance. He responded to my enquiries regarding the correct spelling of the words and supplied his knowledge, although five different scripts of this language have been developed. Unfortunately, it is not the ideal scenario in which to learn the language; for this reason, I often included two spelling versions of the same word if my teacher was not sure about the standard writing of the term. Only recently, a Rohingya grammar has been published (Braun, 2025). Moreover, I included a glossary (see *List of Rohingya expressions & terms*) at the end of the doctoral thesis.

With regard to Bangladeshi terms (which I address to Bangladeshi instead of Bengali, given my interest in Bangladesh and not in the Indian Bengal region), I used Bangladeshi characters, their pronunciation, and a translation. Bangladeshi words are spelled according to the dictionary by Munira (2012) *Oxford Dictionary Bengali to English & English* and the one by Biswas (2004). A simple transliteration system is used, which corresponds to the pronunciation of the word.

Table of Content

Abstract.....	i
Abstract (German).....	iii
Acknowledgments	v
Preliminary Notes	viii
Table of Content.....	ix
 INTRODUCTION.....	 1
1. Research Field	1
2. Limitations of the Research	5
3. Theoretical Framework and Research Gap	8
4. Significant, Original Contribution	14
5. Outline of the Thesis	15
6. Remarks	19
 CHAPTER 1 Methodology	 20
1. A Reflexive Approach, the Role of Languages, Law and History	20
2. Chronology of my Fieldwork	24
3. Research Participants: Marginalised but Multiple Perspectives	28
4. Fieldwork and Participant Observation in Refugee Camps, Rohingyas' "Homes" and Health Facilities	30
5. Collecting and Organising Data: Interviews	32
6. Negotiating Access to Fieldwork	35
7. Concluding Remarks.....	38
 PART ONE. HISTORICAL AND LEGAL DISCOURSES ON THE FORCED MIGRATION OF ROHINGYAS TO AND IN BANGLADESH.....	 39
 CHAPTER TWO Basic Historical Dimensions on Arakan and Rohingya Migration	 40
1. Rohingyas and Their Name	41
2. Colonial Period in Arakan	43
3. The "Partition Process" in Burma and the Border in Arakan	46
4. World War II: pro-Japanese Buddhists and pro-British Muslims in Arakan	52

5. Concluding Remarks.....	54
CHAPTER THREE Literature Review on Rohingya Forced Migration.....	56
1. Post-Independence in Burma and Rohingya Forced Migration (1948, 1959, 1978)	57
2. The 1982 Citizenship Law and the Rohingya Forced Migration of 1991 and 1992	60
3. Rohingya Forced Migration in South and Southeast Asia	63
4. Rohingya Forced Migration in 2012, 2016 and 2017	66
5. Ethnographic Research Related to Rohingyas, Research on Genocide and International Protection	67
6. Concluding Remarks.....	73
CHAPTER FOUR Emic Categories Within Refugee Law.....	75
1. Refugee-Related Law in Asia	75
2. Registered and Unregistered Refugees: Emic Categories and Migration Policies....	78
3. Refugee-Related Law in Bangladesh.....	83
4. Concluding Remarks.....	89
Conclusion of Part One	90
PART TWO. ETHNOGRAPHY OF THE CAMPS: MOBILITY, SOCIAL TIES AND HUMANITARIAN RESOURCES FOR ROHINGYA WOMEN IN THE FIELD OF REPRODUCTIVE HEALTH	91
CHAPTER FIVE Social Exclusion and Survival Strategies of Rohingya Refugees in Bangladesh	92
1. Introduction.....	92
2. Theories on Social Exclusion in Refugee Camps	95
3. Social Exclusion and Hyper-mobility in the Informal Settlement Camp	97
4. Heterogeneous Survival Strategies in the Old Camp	102
5. Isolation Within the “Accidental Community” in the New Camp	107
6. Conclusions.....	111
References.....	113

CHAPTER SIX Rohingya Women's Perspectives on the Medicalisation of Births in the Informal Settlement Camp	115
1. Introduction.....	115
2. The Primary Health Centre in the Informal Settlement Camp	116
3. The role of a Community Health Worker and her Family	118
4. Disease, Death and Certificates like the Birth Certificate	125
5. National Humanitarians' Approach to Family Planning.....	130
6. Rohingya Birth Attendants in the Primary Health Centre.....	134
7. Concluding Remarks.....	140
CHAPTER SEVEN Rohingya Women's Strategies during Home Births in the New Camp	142
1. Introduction.....	142
2. Giving Birth at Home in the New Refugee Camp.....	143
3. The Hospitals in the New Camp	147
4. The <i>Dhoroni</i> 's Registers of Knowledge to Assist Home Births.....	151
5. Birth at Home: A Result of "Traditional Knowledge" and NGO Training	157
6. Concluding Remarks.....	160
CHAPTER EIGHT This Must Be the Place. Giving Birth in the Old Camp	162
1. Introduction.....	162
2. Institutional Perspectives: the Camp-in-Charge Officer and the Site Manager ...	163
3. The Primary Health Centre and the <i>Dhoroni</i> Sufia	165
4. The Authority of the <i>Dhoroni</i> and the Role of Certificates	170
5. The <i>Dhoroni</i> Moriam: Oscillating Between Deliveries at Home and in the Hospital ..	175
6. Concluding Remarks.....	181
Conclusion of Part Two	182
PART THREE. ROHINGYAS' WAYS TO NAVIGATE LABOUR AND DELIVERY: AN ANALYSIS OF SURVIVAL STRATEGIES, FORCED CHOICES, AND ADAPTATION. ...	183
CHAPTER NINE Rohingyas' Ways to Give Birth: An Analysis of Multiple Factors	184

1. Introduction: Rohingyas' Pregnancies and Births Within Their Forced Migration.....	184
2. The National Context, Family Planning and the Notion of Pollution.....	186
3. Global Health Policies and Their Implementation in the "Experimental Battlefield" ...	189
4. The Reports <i>Joint Response Plan</i> and the Humanitarian Rohingya Response ..	192
5. Field Study: Rohingyas' Voices on Childbirth in the Shifting Rules of the Camps	196
6. Concluding Remarks.....	201
 CHAPTER TEN Home or Hospital? An Analysis of How Rohingyas Give Birth in the Camps	202
1. Introduction.....	202
2. Theories: Critiques of the Medicalisation of Births.....	204
3. Field Study: Fears Around the Event of Hospitalised Births.....	207
4. Social Actors: The Role of the Midwives and the <i>Dhoroni</i>	209
5. Reflections on Blood, Practices of Cutting the Umbilical Cord and Burying the Placenta.....	212
6. From the Anthropology of the Body to Survival Strategy, Forced Choice, and Adaptation	216
7. Concluding Remarks.....	224
 Conclusion of Part Three	226
 CONCLUSION OF THE DOCTORAL THESIS Creating New Life Within and Despite Social Exclusion	227
1. Social Exclusion for Rohingya Women in Refugee Camps in Bangladesh	227
2. Key Theories and Additional Theoretical Validation	229
3. Reflections and Research Trajectories	233
4. Creating New Life: The <i>Rosi</i> and the Umbilical Cord	235
5. Summary of the Thesis: Exclusionary Discourses and Births in the Camps	236
 Epilogue.....	242
 List of Rohingya expressions & terms	245

List of acronyms	247
Annex I: Extension of the Refugee Relief and Repatriation Commissioner's permission and related research conditions.....	249
Annex II: Graph illustrating the coordination mechanisms for the Rohingya humanitarian response ISCG (2022, p. 17).....	250
Annex III: List of birth attendants or <i>fuwa dhoroni</i> who took part in this research	251
List of maps and illustrations	252
References	254

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INTRODUCTION

1. Research Field

Anthropological accounts are shaped by reflecting on the epistemological and political forces influencing our writing. My previous work in the legal domain of asylum law has influenced my perspective and created strong expectations regarding the legal analysis of the Rohingyas, and the defining conditions of their social exclusion in Bangladesh. The aim of this thesis is to explore the tension between social exclusion and the persistence of refugees by examining home births in camps, as well as the perspectives of birth attendants. Social exclusion is defined as “an outcome of practices by state and non-state actors that hinder migrants’ access to territory, rights and resources, as well as participation in societal spheres” (Foblets et al., 2018, p. 28). Rohingyas are stateless people who have been displaced for decades from the Rakhine State in western Myanmar to many countries in Asia - 1991 and 1992 displacement is the first known internationally, whereas 2016 and 2017 is the most recent (at the time of writing). Most of them fled to the neighbouring country, Bangladesh, where, at first sight, no refugee-related law is in place. Nonetheless, the analysis of asylum law and related debates remain fundamental to understanding one of the many discourses marginalising Rohingyas. Rohingyas do not belong to Myanmar, where their citizenship has been “stripped” away, and in the refugee camps in Bangladesh they are not recognised either as refugees or stateless individuals.

Both history and law have emerged as important layers of analysis emphasising the inequalities characterising Rohingyas in their struggle to be identified as citizens or refugees. Rohingyas are legally stateless ever since their citizenship has been taken away from them. For this reason, I have decided to focus on pregnancy and birth: in their refugee situation, newly-born Rohingya babies are stateless from the outset, but not even recognised as such. The moment of birth is the very first moment in a human being's life when their belonging to a group, community, or nation is recognised not merely by themselves, but also by outsiders. However, this latter aspect does not occur for the Rohingya people. Thus, I have explored how births take place in the camps and have observed this as a key moment to investigate notions of belonging. In a country where there is no national asylum law, this issue inevitably is connected to policies that have “registered” some Rohingyas in one way or another, whereas the others are left “unregistered”. My

fieldwork in Bangladesh prompted me to reevaluate the role of birth, which constitutes a moment to become citizens, while in the end most Rohingyas are not even recognised as refugees. In fact, some of them had been formally recognised as refugees in the past. The government of Bangladesh to an extent recognised Rohingyas as refugees up to 1991, but because of the absence of asylum law and the shift in policies in the country Rohingyas who arrived later are now excluded from any kind of status recognition. Thus, exclusion is also dependent on the shifting context of policies. For this reason, part of the present analysis centring around Bangladeshi law on foreigners has gone beyond legal categories to provide a better understanding of the social context and policies affecting the Rohingyas.

Exploring the main purpose of the present PhD thesis involved my ethnographic fieldwork and source analyses to explore how the camps are divided in Bangladesh, why there are differences between old camps and new camps, and why the proportion of home births is not evenly distributed across the camps. I hypothesise that these differences are related to policies, national and international regulations, as well as the broader discourses of social exclusion. This work focuses on the marginal perspectives of Rohingya women to tackle various layers of social exclusion in the field of reproductive health. The main participants in this research are Rohingya pregnant women, new mothers and *fuwa dhoroni*,¹ (“child pullers”), or birth attendants. They have taught me that in Rohingya speech practice, the word indicating the place of origin of a person literally means the place where the umbilical cord has been cut and buried. So, they have drawn my attention to the importance of places and practices during birth. This work aims to engage with different experiences of Rohingya women during childbirth in three camps. The camps are indicated according to one of their characteristics, instead of using their actual names of reference.² The “informal settlement camp” used to be a makeshift settlement of Rohingyas since around 2008, until authorities recognised it as a camp in 2017. The “old camp” has been established in the 1990s, and the “new camp” was opened in 2017 in an area where there had never been a camp before. In each camp, I regularly visited the research participants in their shelters over a period of twelve months. For many Rohingyas who used to live in Bangladeshi villages before 2017, on one hand, resettling in camps has been a way to access a range of resources provided by the humanitarian institutions. A smaller group of individuals in the old camp has described life in the camps as the only life they have known for more than thirty years. On the other hand, new camps are primarily populated by Rohingyas who arrived in

¹ A shortened form is *dhoroni*, puller, and a synonym is *daima*.

² The names of the research participants have also been changed to maintain their anonymity.

the country in 2017 after having undergone persecution in Myanmar. Therefore, topics like forced migration or the hope of going back to their hometowns are more common. Working with Rohingya women consolidated and inspired my study of childbirth, as the concept of birth itself is, in fact, a crucial rite of passage in people's lives (Newman, 2001), especially in a context of displacement and statelessness.

The expression *naghi harha desh*, “country where the navel is cut”, in Rohingya indicates the place of origin and is literally the place where the newborn's navel, *nar*, “umbilical cord”, has been cut. This expression redirects to the primordial significance of birth-giving practices being strictly related to the Rohingyas' origin but also to their life in camps. In other words, these practices are closely tied to the places where they pursue their lives. I have encountered many Rohingyas during my fieldwork in refugee camps who have described their regret of being away from their *desh* because this is where their *nar* and *ful*³ had been buried. For the same reason, other Rohingyas, who are born in Bangladeshi camps have refused to take part in the returns organised in the 1990s by the government of Bangladesh and the United Nations High Commissioner for Refugees. “*Naghi harha*”, the cutting of the navel, acquires a broader meaning for Rohingyas because it indicates where they come from, reflecting how they live and what kind of changes they have experienced after their forced displacement. In the refugee camps, they barely have sufficient space to bury their newborns' placentas, which are often dismissed by hospital personnel. Exploring the practice of childbirth therefore has been crucial in investigating the new dynamics of power and authority that emerged in the context of the camps.

The discourses concerning the social exclusion of Rohingyas are influenced by the institutional social actors as well. The United Nations (UN), Non-Governmental Organisations (NGOs), and various international organisations in the Rohingya response may provide certain resources to Rohingyas in the camps on the basis of specific documents. During my preliminary research stays in 2019 and 2021, I became acquainted with the শরণার্থী ত্রাণ ও প্রত্যাবাসন কমিশনারের কার্যালয়, *shornartha tran o protobasan komisonarer karjaloy*, refugee relief and repatriation commissioner (RRRC) office, established in 1992.⁴ The Office granted me permission to conduct research within the Rohingya refugee camps under precise conditions. Moreover, the person in charge of the camp – known as “Camp in

³ *Nar* means umbilical cord and *ful* placenta.

⁴ For more information, see the Refugee Relief and Repatriation Commissioner's Office website, available at: <https://rrrc.gov.bd/>.

Charge” - must be duly informed of my presence and allow my activities. Referred to as “CIC”, each “Camp in Charge” person is the governmental representative responsible for managing a single camp or two smaller camps, thus the decision-making authority.⁵ During each visit to a new camp, I needed to engage in dialogue with this CIC, requesting their signature on my authorisation form (shown in Annex I). These formalities along with institutional conversations have provided me with insights into how Bangladeshi bureaucracy handles the Rohingya humanitarian response, perceives the refugee population and, first and foremost, the prevailing power dynamics towards Rohingyas. The officer responsible for the “Site Management and Development” sector is typically situated, except for the two older camps, in an office within the same building as the CIC staff. From this office, a non-governmental organisation (NGO) is assigned the task of managing the camp as an implementing partner of either the United Nations High Commissioner for Refugees (UNHCR) or the International Organisation for Migration (IOM). These two United Nations agencies have played a concurrent role in the Rohingya Response since 2017 and are recognised as principal partners of the Bangladesh government, although the UNHCR has been part of the humanitarian response for Rohingyas since the 1990s. However, the camp structure indicates that both organisations in local practice are subordinate to the government.

Each organisation manages an equal number of sites: 16 camps overseen by the UNHCR and 16 by the IOM. While the two older camps - namely, Kutupalong and Nayapara registered camps -⁶ were established between 1991 and 1992, the other 32 camps were settled in 2017. Over 30 years ago, the UNHCR was the primary partner alongside the NGO Concern Worldwide in addressing the Rohingya response in Bangladesh. Consequently, the UNHCR has maintained its role as site manager for the two older camps. In the remaining 31 camps,⁷ the UNHCR and the IOM frequently delegate site management responsibilities to other NGOs, namely BRAC,⁸ the Cooperative for Assistance and Relief Everywhere (CARE), HELVETAS, and ActionAid.

On a national level, the “National Task Force” in Dhaka consists of the Ministry of Foreign Affairs Chair, the Government Ministries and occasionally the UN agencies. The National Task Force collaborates with the Ministry of Disaster Management and the Ministry of Relief

⁵ Apart from a female “camp-in-charge” person, who was mentioned to me during an informal talk, all “camp-in-charge” persons are male.

⁶ About the name of the two old camps as “registered camp”, see section 2 of chapter 4.

⁷ Camp 23 (Shamlapur) was managed by the IOM, but was closed during my fieldwork in 2022.

⁸ Initially founded as the Bangladesh Rehabilitation Assistance Committee and then renamed the Bangladesh Rural Advancement Committee, the Bangladeshi organisation is today known as BRAC.

to represent the governmental coalition in the Rohingya response, formally at the same level as the humanitarian stakeholders, the Strategic Executive Group. In the role of co-chairs, the Strategic Executive Group consists of the IOM - which is represented by its Chief of Mission- the UNHCR - by the country representative - and the UN resident coordinator (see the chart, Annex II). The principal Coordinator of the Inter-Sector Coordination Group (ISCG) Secretariat ensures the coordination of the Rohingya response that is accomplished through nine sectors.⁹ Each sector regulates the services in the camps according to its area of responsibility (ISCG, 2023, p. 16). The response is visually explained in Annex II showing two parallel systems – the governmental representatives and the humanitarian social actors. However, they are not on a position of equality since the Bangladeshi institutions are the real decision-makers. For this reason, authorities in Bangladesh can make certain camp decisions and promote certain policies without necessarily abiding by the law. Humanitarian organisations may have some influence in the implementation of these policies, although they play a minor role. Institutional social actors are important players in this study as they provide Rohingyas with regular resources and can make decisions influencing their life in the camps. This thesis aims to tackle social exclusion and the persistence of Rohingya women by examining births in the camps.

2. Limitations of the Research

I initially began developing this research at my workplace as a caseworker for asylum seekers in southern Italy. I was working in western Sicily, closely interacting with male asylum seekers and refugees from Bangladesh. When applying for international protection, asylum seekers share their stories, which authorities use to determine their eligibility. During one interview, a Bangladeshi asylum seeker identified as belonging to the Rohingya ethnicity, prompting my study of Rohingya forced migration to Bangladesh. As I conducted online research for my job, several questions arose: how do Rohingya refugees navigate forced migration in a neighbouring country like Bangladesh? Do they try to assimilate in Bangladesh? What is daily life like for them in camps? Moreover, most Bangladeshi asylum seekers in Italy are male, whereas more than 51% Rohingyas are female in the camps of Bangladesh (ISCG, 2024, p. 12). Hence, I found myself reflecting on the experiences of

⁹ Initiated by the Emergency Relief Coordinator and the Inter-Agency Standing Committee, in 2005 the humanitarian reform process implemented a principle of coordination through the system of sectoral working groups, called “clusters” (OSCE & UNHCR, 2014, p. 14). In emergencies involving refugees, activities are grouped into “sectors”.

women. How do Rohingya women cope in camps? Are there families living outside those camps? With these questions in mind, I travelled to the region twice for preliminary research: once in November 2019 before my PhD project began and again from November to December 2021.

During my PhD project, the research process has allowed me to reconsider several points that initially seemed indisputable. At the beginning of my preliminary research, I was particularly surprised by one fact: after Rohingyas' massive influx to Bangladesh in 2017 when almost 700,000 fled Myanmar and took shelter in Bangladesh (ACAPS, 2017),¹⁰ their migration appeared not so extreme in terms of spatial and cultural differences. In other words, most Rohingyas are Sunni Muslims, which is similar to the majority of Bangladeshis, and their dialect is closely related to the local language spoken in southeast Bangladesh, where many Rohingyas currently reside. They also share numerous cultural aspects with the local Bangladeshi population, known as Chittagonians. Despite the similarity in their religious background, the Chittagonians still distinguish themselves from the Rohingyas (Grillo, 2025, p. 91) as the latter are refugees, considered one of the most marginal groups in Bangladeshi society (Guhathakurta, 2017; Uddin, 2020). My previous job allowed me to learn about Bangladesh, its history and language, and particularly the Rohingya migration. However, I quickly found that my background in refugee law and applied anthropology presented a structural and intellectual challenge at the onset for my PhD project. Not only was I ineligible for pertinent scholarships, and some anthropologists criticised my work in asylum law with a European organisation because they criticised Europe's asylum policies.¹¹ Moreover, my knowledge about general refugee-related law soon appeared to be quite limited for Bangladeshi contexts, hence I had to explore its application in Asia. Furthermore, institutionalised procedures for studying anthropology in the European Union tend to refrain from acknowledging applied or practical professional work outside academia despite applied anthropologists significantly outnumbering academic anthropologists.¹²

Above all, the migration of Rohingyas to Bangladesh has a long history. Hence, knowledge of the historical context is necessary before addressing the legacy of colonialism, the experiences of the Rohingyas, and also their proximity to the local Bangladeshi

¹⁰ "ACAPS", which published research on Rohingyas in Bangladesh, stood for "Assessment Capacities Project". Since today their main tasks deal with humanitarian data and analysis, therefore, "ACAPS" is not officially spelled out anymore to avoid confusion.

¹¹ As a result of the implementation of migration policies in Europe, I outline elsewhere some of the legal challenges that Bangladeshi asylum seekers face when applying for asylum in southern Italy (Grillo, 2021).

¹² Attending the roundtable *Anthropology Outside Itself*, organised by Sohini Kar and Andrea Flores, at the 2023 Association of Social Anthropologists conference in London, allowed me to articulate these thoughts. Two contributions have notably influenced my perspective (Lewis, 2023; Mills, 2023).

population. Another limitation in this research is that it does not analyse the data collected from Chittagonians because they are not direct participants of the research, although many similarities are observable between the Rohingyas and Chittagonians, as they are part of the same borderland region.

The flexibility of fieldwork critically reassesses and reevaluates certain misconceptions I had prior to conducting my research. One of my mistakes was the initial interest in conducting research with Rohingyas living outside the camps. I was determined to pursue this research focus as it could show that, although Rohingyas are not legally recognised as refugees, their life outside the camps helps them navigate their precarity, and they can regularise their status in various informal ways. As soon as I started my fieldwork, however, I realised that getting in contact with Rohingyas outside the camps would have been far too complicated, which put unsustainable pressure on my schedule of one-year fieldwork period. Besides, during the first weeks of my fieldwork, my intention to focus on various experiences of social exclusion took a different direction. In fact, one of the main challenges of the present study was defining “social exclusion”. During my fieldwork, institutions started implementing the policy of medicalising births, so my work narrowed down to the social exclusion experienced by women, specifically during childbirth.¹³

The intersectional approach sustains my choice to embrace the diversity of experiences of social exclusion (Gu, 2017), often obscured by policies and humanitarian discourses (Cho et al., 2013).¹⁴ The notion of “ethno-sexual frontiers” - specifically, the intersections of racial, ethnic, or national boundaries defining the edges of these frontiers (Nagel, 2003, pp. 1, 14) - highlights the experiences of refugees facing gender-specific practices of exclusion.¹⁵ The present work attempts to investigate the perspectives of several Rohingya women from three camps, who have fled at different times and play various roles involved in births.

¹³ I decided to focus on this topic, given my research interest in working with women, the help I received from the historian Pascal Bourdeaux who put me in contact with the NGO Friendship, the positive response of the organisation to visit its health facility in the camp area, as well as the many birth attendants I encountered in the camps, specifically upon a suggestion by Eva-Maria Knoll.

¹⁴ For example, none of the official humanitarian reports on the Rohingya response mentions information on Rohingya birth attendants. The discourse surrounding birth and reproductive health in the *Joint Response Plan* reports (see chapter 9), published annually on the humanitarian response, has shifted throughout the years. The initial interest of NGOs in legal issues regarding the stateless Rohingyas’ quest for identification was combined with the plight of Rohingya newborns in obtaining birth certificates, whereas later the humanitarian discourse fixated for several years on other issues in the domain of reproductive health. Recently, its focus has shifted towards nutrition.

¹⁵ The connection between ethnicity and sexuality is explained through discourses that oppose the “standard sexual behaviours” to the ethnic “Other”, and enforce the ethno-sexual constructions and boundaries among different groups (Nagel, 2003, p. 10).

However, it does not directly reflect on the relations across the various “sections”.¹⁶ Moreover, this research does not delve into the feminist debate and notions of reproductive rights and reproductive (in)justice (Davis, 2019; Ross & Solinger, 2017). Still, it bases part of its analysis on the contribution of some academics who have researched reproductive health in the geographical Global South and the Global North. Furthermore, this work does not directly address topics such as rape, fertility, infertility, motherhood or childlessness (Nahar, 2021; Siegl, 2023; Taslima Sultana, 2025). Instead, it approaches reproductive health as a field to examine social exclusion from Rohingya women’s perspectives. My aim is to explore social exclusion and women’s persistence within the broader academic debate on refugees. The present work offers detailed insights into births in the camps, which can be connected to future research on refugees’ ways to cope with their general condition of social exclusion.

3. Theoretical Framework and Research Gap

This section discusses in its first part the theories referred to in this doctoral thesis and in the second part the research gap. My interest in examining the condition of the Rohingyas through the lens of social exclusion originates from the concept’s established definitions and debates within academic discourse. Social exclusion encompasses the specific effects of negotiated norms in a social or legal context. As already mentioned, it is specifically defined as “an outcome of practices by state and non-state actors that hinder migrants’ access to territory, rights and resources, as well as participation in societal spheres” (Foblets et al., 2018, p. 28).

To begin with, a conventional legal framework would equate refugee protection with the mere application of asylum law. In this context, Harrell-Bond and Voutira, anthropologists who have extensively contributed to the study of refugees, argue that many countries in the Global South tend to view the “definition of refugee rights as impositions of Western values” (Harrell-Bond & Voutira, 1992, p. 7), which were drafted in post-war Europe primarily to protect the refugees of the Holocaust.¹⁷ Maja Janmyr’s work on non-signatory countries of the 1951 *Geneva Convention Relating to the Status of Refugees*, points out that, although

¹⁶ This research involves pregnant women and birth attendants of various ages who live in one of three camps and migrated in 1991, 1992, 2012, 2016, or 2017 to Bangladesh. They were all persecuted and fled from different towns in Rakhine State, but in different years, and have been living in refugee camps for varying durations (see annex III, *List of birth attendants or fuwa dhoroni who took part in this research*).

¹⁷ With the 1967 Protocol, the temporal and geographical limitations of the 1951 Geneva Convention Relating to the Status of Refugees have been abolished to extend the convention elsewhere.

no country in South Asia has signed the 1951 Geneva Convention, non-signatory countries still engage in the protection of refugees (Janmyr, 2021).¹⁸ Moreover, key contributions from the “Third World Approach of International Law” (i.e., TWAIL), as well as the legal scholar Bhupinder S. Chimni, emphasise the exclusion of “Third World” countries from the drafting process of refugee-related laws, and argue that each migration should be contextualised separately. Last but not least, the objective of humanitarian responses and migration policies aims to contain refugees in the “Global South” (Chimni, 1998).¹⁹ Hence, the importance of going beyond the understanding of exclusion just in terms of rights.

Generally, Rohingyas experience imposed boundaries across various aspects of life in Bangladesh, and this reflects the undesirability of non-citizens representing an external stigmatisation after crossing the border (Khosravi, 2019, p. 23). The concept of “boundary” allows for zooming in on the Rohingyas’ experiences in Bangladesh as it signifies the identity and limits of a community of individuals who share something in common while distinguishing themselves from other groups in their interaction (Barth, 1969; Cohen, 1993, p. 13). Reflections on imposed boundaries and categories (Donnan, 2001, p. 1292) are important as they lead to the notion of the “border gaze”, which views gender, class, and racial boundaries as being more exclusive than the physical border (Khosravi, 2019, p. 135). The border gaze is enforced through these boundaries, locating refugees outside any temporal dimension and not recognising them as a community (Agier, 2008, p. 40). Invisible borders, such as the border gaze, often place migrants on the threshold between the inside and outside of society, disempowering them while demanding their participation.

Social exclusion can be effectively explained through the notion of the multiplication of “boundary-drawing” practices. As a “non-linear continuum” (Foblets et al., 2018, p. 28), it consists of various moments of exclusion that occur in different forms, such as everyday boundary-drawing according to various sets of laws in the host country (Lems, 2020). Boundary-drawing practices, which permeate the social domain of refugees’ everyday life, acquire prominence as the constitutive aspect of the experience of exclusion (Lems, 2020, p. 116). Social actors like international NGOs might also activate these “internal frontiers” (Lems, 2020), and in the context of refugee camps, they exert power arbitrarily (Agier, 2011,

¹⁸ Bangladesh did not sign the 1951 *Geneva Convention Relating to the Status of Refugees*, the 1954 *Convention Relating to the Status of Stateless Persons* nor the 1961 *Convention on the Reduction of Statelessness*. Nevertheless, the country is party of the *Universal Declaration of Human Rights*, where article 15 claims that: “Everyone has the right to a nationality. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality” (*Universal Declaration of Human Rights*, 1948).

¹⁹ Similarly, while questioning the relationship between law and society, feminist scholars such as Charlesworth and Chinkin (2022) argue in the book *The Boundaries of International Law* that the absence of women in the creation of international law has led to an inadequate and limited understanding of it.

p. 49). The ambivalence of NGOs helping and governing refugees is illustrated by the title of Verdirame and Harrell-Bond's book, which metaphorically addresses the "Janus' face of humanitarianism".²⁰ Hence, it is crucial not to dismiss the impact of organisations on decision-making processes, internal structures, hierarchies, and inequalities among migrants (Lang et al., 2021, pp. 8, 11). Within the "meso-level" of NGOs, it is essential to consider the concept of "biopolitics" as the decisions and discourses of humanitarian social actors shape everyday life in the camps. In this regard, life in refugee camps is often described through the notion of "bare life" because refugees are able to live only the biological dimension of their existence, without any other guarantee (Agamben, 1998). Nevertheless, the anthropologist Didier Fassin argues against this view by shedding light on the space for refugees to have a political life as well and underlines that NGOs' objective is to alleviate people's suffering rather than merely controlling them (Fassin, 2010, p. 453). This discussion leads to the broader debate between exclusion and agency, crucial in the study of forced migration. In this regard, Aradau and Tazzioli (2020) challenge the binary opposition between agency and victimhood in migration studies and propose the concept of "biopolitics multiple", inspired by Paul Rabinow's and Nikolas Rose's work (Rabinow & Rose, 2006; Rabinow, 1997). The notion refers to various forms of control, the activation of multiple horizontal resources related to interactions with other groups and the context in which refugees migrate and live (Grillo, 2025, p. 93).

The gender component plays a crucial role in the analysis of refugees' exclusion (Chakraborty & Bhabha, 2021), alongside the notion of survival strategies, which provides more space for people's action. The authors of the article *"We are All Refugees" : Camps and Informal Settlements as Converging Spaces of Global Displacements* describe and compare the "survival strategies" activated in a slum in the proximity of Dhaka to a refugee camp (Huq & Miraftab, 2020). Similar research interests are highlighted in the work among marginalised urban poor women in Dhaka, with an emphasis on protection and survival mechanisms (Kiriam & Skuse, 2024).²¹ The concept of refusal is also addressed as a response that Rohingyas activate in a context of violence (Prasse-Freeman, 2023, p. 434), but among women in a camp the term "survival strategies" is more appropriate. Survival strategies aim to manoeuvre the space "between the state and non-states actors" to deploy specific resources and reach particular interests (Huq & Miraftab, 2020, p. 363). Refugees

²⁰ Janus, the Roman god of transitions and dualities, is portrayed with two faces and represents the behaviour of pretending to have a feeling but acting according to another.

²¹ The subaltern studies are essential to examine marginal perspectives in South Asia (Aithal, 2004; Guha, 1997; Spivak, 2010), and have been included in the analysis of the multiple layers of social exclusion in chapter 9.

negotiate their condition of social exclusion (Johnson & Gilligan, 2021), which, however, might still lead to the severity of their coping strategies (Al Zoubi, 2023; Soheli et al., 2024). Academic work has demonstrated that there is a way between social exclusion and agency, for example, in the form of survival strategies.

Contributions from the anthropology of birth concentrate on the medicalisation of births and the introduction of hierarchical structures in reproductive health (I. Ali et al., 2021; Davis-Floyd & Sargent, 1997; Jordan, 1997; Martin, 1987; Oakley, 1984; Rozario, 1998; Towghi, 2024). A considerable amount of literature has been published on the hierarchies in hospitalised births, especially in the geographical Global South. These studies are central in my analysis of the ethnographic data in part three. Anthropologist Livia Wick points out how new mothers in Palestine are rather confronted with a sense of isolation, confined to their homes, fear and loss after giving birth, especially due to their restricted mobility (Wick, 2023, pp. 30, 31). She focuses on the sense of isolation that pregnant women feel in their homes, along with their need for contact with relatives, and the persistence (Wick, 2023, p. 34). Additional layers require to be explored among refugee women (Lowe, 2019) and in refugee camps, especially given the social exclusion that women face in the reproductive health sector of the camps.²²

The organisations in the health sector have encouraged pregnant Rohingya women to attend health facilities in the camps, to give birth there thus reducing maternal mortality,²³ but most of them prefer home deliveries for various reasons. Specifically, in 2018, 22% of births occurred in health facilities (BRAC, 2018), and maternal mortality was presumed due to the scarce number of births in hospitals (Parmar et al., 2019). Mortality is caused by three types of “delays” to reach the health facility: the decision-making process of pregnant women, the accessibility of facilities and overall conditions in camp hospitals (Parmar et al., 2019, p. 41). Sexual and reproductive health is defined as a “right and a critical need” by some scholars (Jannat et al., 2023, p. 856), and initiatives like the Minimum Initial Service Package (also addressed as “MISP”, see footnote 23) are fundamental in case medical intervention during childbirth is required, as well as in case of transmission and treatment of sexual diseases (Yousuf et al., 2020, p. 166). However, the risk is that the medicalisation of

²² In the Rohingya response in 2022, there used to be thirteen sectors. Later, these have been reduced to nine. For this reason, the “Site Management and Site Development” sector has been merged with the “Shelter and Non-food Items” (ISCG, 2022, 2023).

²³ The World Health Organisation has implemented the Minimum Initial Service Package (MISP) in the camps to provide sexual and reproductive health services in humanitarian contexts (R. Ahmed et al., 2020, p. 3; M. A. Hossain et al., 2025, p. 2).

births turns health-based facilities into a sort of “imposed need” or “Imposed Aid” (Harrell-Bond, 1986) as Barbara Harrell-Bond claims in her research with refugees in South Sudan. It is not my objective to argue against the significance of sexual and reproductive services for refugees in camps. Nevertheless, it is interesting to identify the patterns and, at times, the biases of research in this field with the Rohingyas in camps. Medicalisation of births usually refers to the “overuse of medical interventions even in low-risk pregnancies and childbirths” (Spina, 2023, p. 2), but in this context of refugee camps, already attending the health facility is perceived as a medical intervention, and hence medicalised births here refer to births in health facilities. To examine the medicalisation of births in the camps requires in-depth readings on, at least, the birth practices in Myanmar and the camps in Bangladesh.

There is limited knowledge regarding the birthing practices of Rohingya individuals in Myanmar; anthropologist Claude Delachet-Guillon pursued ethnographic research on midwifery in Arakan (Delachet-Guillon, 2000). Otherwise, literature on midwifery focuses on other countries in Asia or other areas of Myanmar (Griffin et al., 2023; Kernohan et al., 2018; Sheehy et al., 2016). What is evident from these contributions is that, in Myanmar, ethnic conflict, travel restrictions, and lack of infrastructure have led to a higher number of births at home. As for the Rohingyas, access to hospitals and formal education necessary for becoming a midwife has been exceedingly challenging, both financially and due to discrimination, leading to higher levels of maternal mortality among Rohingyas in 2013 than other citizens (US Department of State, 2014, p. 37).²⁴ Concerning the Rohingyas’ condition in Myanmar, a two-child policy has targeted their births, and in case of a third pregnancy leading to risky abortions, which are forbidden (Anwary, 2022, p. 413). Besides, marriages have also been restricted before their forced displacement, and Rohingyas had to obtain permission from security forces in exchange for bribes to reach hospitals in case of medical emergency (Anwary, 2022, pp. 411, 413).

Once in Bangladesh, discrimination in the health facilities and the lack of employed Rohingya personnel contribute to the scarce number of facility-based births in the camps (Parmar et al., 2019, p. 44). The World Health Organisation manages the health sector in the response, in which the sexual and reproductive health “sub-sector” is the competence of the United Nations Population Fund (UNFPA);²⁵ still, the governmental representatives on behalf of the Ministry of Health and Family Welfare have also put a consistent effort in

²⁴ In 2013, maternal mortality among Rohingyas in Myanmar reached the estimate of 400 every 100,000 births, whereas among the rest of women in the country this amounted to 200 deaths per 100,00 live births (US Department of State, 2014, p. 37).

²⁵ The UNFPA original name was United Nations Fund for Population Activities, which was changed in 1987.

the implementation of family planning programmes (R. Ahmed et al., 2020, p. 4). In particular, family planning programmes represent a main priority for the government, unlikely to be disseminated by the NGOs as they are a “taboo” for the Rohingyas (Abul Kalam Azad et al., 2022, pp. 9, 10; Jannat et al., 2023, p. 865). Most of these contributions fail to analyse critically the stance of local institutions and support the widespread view that NGOs do not promote family planning policies because Rohingyas are unwilling to embark on contraceptive methods. Much of the literature in this field highlights the vulnerability of Rohingya women, reiterating that due to their “conservative” views, pregnant women do not attend health facilities in the camps (R. Ahmed et al., 2020, pp. 2, 4; Yousuf et al., 2020, p. 164). Literature reviews identify a lack of emphasis on interventions prioritising home births and criticise the tendency of other studies to overgeneralise cultural viewpoints (M. A. Hossain et al., 2023, p. 37, 2025, p. 15). A few contributions counterbalance the image of Rohingya women as victims and vulnerable and emphasise their struggles to survive in Myanmar. (Anwary, 2022, p. 411). Afroza Anwary’s contribution is unique in that she attempts to present Rohingya women’s perspectives on their persecution in Myanmar with a focus on sexual violence without shaping information through “operational definitions” (Anwary, 2022, p. 416). Similarly, other authors like Priddy, Doman, Berry and Ahmed point out the importance of making visible the voice of female Rohingyas who are often overlooked (Priddy et al., 2022, p. 226). In this regard, many studies that shed light on the lack of information as the main cause why Rohingya women do not use healthcare services (Jannat et al., 2023, p. 860) do not consider the Rohingya birth attendants’ knowledge, and the fact that there is a reliable system of knowledge present elsewhere in the camps to assist pregnant women. This explains why in March 2018, 73.7% of pregnant women delivered at home “without a certified birth attendant” (Bhatia et al., 2018, p. 115), and around 60,000 women were pregnant (M. A. Hossain & Dawson, 2021, p. 3; UNFPA, 2018, p. 1). The gap in the research on home births and the perspectives of Rohingya birth attendants constitute a starting point for me to elaborate the questions for the present study.

For the reasons indicated in this section, the present thesis combines theoretical contributions from “refugee studies” (inspired by the works of Harrell-Bond & Voutira, Chimini, Khosravi and Agier), “the anthropology of birth” (inspired by the works of Martin, Oakley, Rozario, Jordan, Towghi, and Wick) and “legal anthropology” (inspired by the work of Foblets et al). Given the various contributions on refugees’ social exclusion and the idea of persistence that emerges from Livia Wick’s contribution on pregnant women, this work

aims to explore new layers, especially in connection with the social exclusion that women face in the reproductive health sector in refugee camps.

4. Significant, Original Contribution

Institutions like NGOs, the UN and the government of Bangladesh encourage pregnant women to attend health facilities to reduce the rate of maternal mortality. The government is also supporting this policy for another purpose, which is to implement family planning programmes and contain the population in the camps. Because of the persecution Rohingyas have endured in Myanmar, also in the field of reproductive health (the implementation of the two-child policy, no access to hospitals nor to the midwifery curriculum), as well as for the discrimination they experience from the Bangladeshi medical personnel in the camps (they are treated poorly as they are considered illiterate women who undergo multiple pregnancies, birth attendants' expertise is marginalised and newborns delivered at home are denied birth certificates), they tend to avoid health facilities and prefer to give birth at home. Studying and examining their understanding of births without just labelling it as *a priori* "conservative" or "orthodox" might help comprehend this life event, the different approaches of women independently of their roles in the humanitarian response, and facilitate not only the position of Rohingyas, but also help implement policies more effectively.

How do various levels of social exclusion intertwine during births from the perspective of Rohingya women living in three camps, established in Bangladesh both formally and informally in three different periods (1991, 2010 and 2017)? Given the precarious living conditions for Rohingyas in the camps of Bangladesh, and the availability of health facilities in almost every camp, why do many women in the new camp prefer to stay in their shelters, whereas in the old camp, most Rohingyas attend the health facilities to give birth? Why have an ever-growing number of women started giving birth in hospitals in the informal settlement camp? How do Rohingya women experience social exclusion in terms of the norms within the camps, including the ones arising from the government of Bangladesh, NGOs and other humanitarian actors, that require Rohingyas to give birth in the health facility and follow family planning programmes, while respecting their cultural and social norms?

My original contribution is to examine home births, as well as the perspectives of birth attendants that are unexplored in previous works with Rohingyas. Besides, it is grounded

on its approach of social exclusion from the perspectives of women, highlighting their narratives and focusing on their lived experiences, which remain marginalised. In 2022, year of my fieldwork, NGOs and the UN invested considerable efforts to medicalise births in the camps, and the present research is based on the fact that these funds could have been used to employ more Rohingya birth attendants in the health facilities and alleviate the tensions in the interaction between pregnant women and the medical personnel. Moreover, money could be invested to train birth attendants to assist pregnant women with their deliveries in their shelters. This latter point is crucial as soon as funding for the Rohingya response is reduced. Last but not least, examining the experiences and perspectives of refugee women in the camps could help identify and alleviate exclusionary dynamics and discourses affecting the life of several Rohingya women.

In the context of refugee camps, given the arbitrary exercise of power and biopolitics (Foucault, 2004), which might be applied to study policies in the field of reproductive health, and the various roles that Rohingya birth attendants play, the present study focuses on how Rohingya women navigate life in the camps. Rohingya women experience various levels of exclusion but activate multiple strategies that empower themselves. These levels of exclusion are impacted by various factors: their past experience of persecution in Myanmar, which has affected them also during their pregnancies and childbirths; the condition of protracted displacement; their unrecognised legal status or recognition according to various governmental policies implemented in different periods. Moreover, this contribution expands on the knowledge of Rohingyas who are non-citizens, a significant topic especially in a world where extreme right-wing governments and regimes expel migrants and refugees by merely denying them fundamental rights. Birth attendants assisting pregnant women in three camps are an example of how Rohingya women still manage to give birth their own way, despite the general condition of exclusion. They make decisions within the restricted and continuously changing context of refugee camps and accordingly choose where and how they give birth. In this scenario, social exclusion assumes various meanings through the experiences of the research participants, and their experiences deserve attention as they are inspiring for many other refugees and migrants worldwide.

5. Outline of the Thesis

The thesis begins with the Introduction, which presents the research field, outlines its limitations, and establishes the theoretical framework underpinning the study. It also details

the significant and original contribution of the research and concludes with this outline of the thesis. This thesis not only investigates Rohingya forced migration, which has led thousands of Rohingyas to live in protracted displacement in refugee camps in southeastern Bangladesh, but it primarily examines social exclusion characterising life of Rohingya women in three selected refugee camps in Bangladesh, concentrating in particular on the discussion about childbirth and the birthplace.

Chapter 1 outlines the methods and my one-year fieldwork, undertaken in line with a reflexive approach, along with engaging with the research participants to whom I have always attempted to give something back for their support. The chapter describes the methods, the phases of the research, participant observation, interviews and why they have been selected to collect data in the camps. Finally, this chapter highlights the challenges to access fieldwork, the importance of history, law and language, which are discussed in part one.

Part one (chapters 2 - 4) - "Historical and Legal Discourses on the Forced Migration of Rohingyas to and in Bangladesh" - discusses main colonial and post-colonial background dimensions in Rohingya forced migration and begins from the notion of "forced migration" to highlight the importance of history and law. Chapter 2 gives a basic overview of the history of Arakan and Rohingya migration. The demography in Arakan was already heterogeneous in the pre-colonial times. British rulers supported the migration of various people within the Indian subcontinent, and resentment of local Burmese people increased against some minorities. This sentiment aggravated in the partition and post-independence period, it turned into discrimination, especially when borders and migration started being controlled more strictly. Basic historical analysis, the colonial rule and the nation-building process are crucial to study the Rohingya's recent forced migration. Chapter 3 introduces the forced migration of post-independence times, as well as the relevant contributions on Rohingya forced migration. The criminalisation of certain people in Burma intensified in 1948, due to instability in the region caused by separatist movements and the militarisation of the border with East Pakistan. Hence, Rohingyas were forced out of Arakan in 1948, 1959 and 1978 within a general anti-migrant narrative promoted by the military who confiscated their land. After the 1982 citizenship law stripped the Rohingyas of their citizenship, Rohingyas fled to Bangladesh and other Islamic countries, and recent displacement occurred in an atmosphere of Islamophobia and violence in 2012, 2016 and 2017. Chapter 4 challenges the notion of "Asian exceptionalism" meaning that many Asian countries have not signed

international agreements about asylum law, which does not necessarily imply critical conditions for refugees in these countries. National analysis shows that there are alternative systems to grant refugees basic rights, which are sometimes threatened by political trends. Emic categories are used to examine the relevant policies, as well as how Rohingyas interact with local people and institutions. Part one explains how people's movements in the region were once fluid, but during colonialism and subsequent nationalism certain groups started being criminalised, especially in border regions. The notion of "forced migration", as addressed in Banerjee and Samaddar (2019), underlines the importance of history and legal debates to examine differences among Rohingyas through broader discourses, and thus provides a starting point to collect ethnographic material.

Part two (chapters 5 - 8) – "Ethnography of the Camps: Mobility, Social Ties and Humanitarian Resources for Rohingya Women in the Field of Reproductive Health" – points out the various resources available for Rohingyas, despite their forced migration and social exclusion. It begins with chapter 5, which constitutes the spatial experience of exclusion by presenting the three camps this project engages systematically with, as well as survival strategies among Rohingyas. These strategies, the role of local people and relatives, friends and affinities in the camps give a first account of three refugee camps and their stories. The present chapter is published in the book *Reshaping Rohingya Futures: Coping Strategies and Emerging Agencies*, edited by Nasir Uddin (Uddin, 2025), and may present some repetitions.²⁶ The ethnography further examines the perspectives and experiences of Rohingya women concerning birth. Chapter 6 analyses the medicalisation of births in the informal settlement camp, which is located in an area where NGOs are prominent. It examines the social exclusion of Rohingya women through the medicalisation of births, which has contributed to a top-down approach of the Bangladeshi medical personnel towards the Rohingyas. After reflecting on my fieldwork in the primary health clinic, the chapter discusses the role of Rohingya birth attendants, the importance of certificates in camp life, and the role of the nationals employed in the humanitarian response who are primarily concerned with family planning policies. Rohingya community health workers are more appreciated than birth attendants, as they convince pregnant women to regularly attend the hospital. On the other hand, birth attendants work to assist in delivering babies within the hospital hierarchical structure. Chapter 7 showcases ethnographic materials on home births in the new camp. The chapter introduces the health facilities present in the

²⁶ The University of Vienna allows PhD students to use already published chapters in their doctoral thesis, but these need to be included in the same layout as the publication. To follow this rule, the thesis might repeat some parts published in this contribution. In this case, the published work is quoted accordingly.

camp and the role of birth attendants who have been fired from the health sector. Some Rohingya birth attendants are aware of Rohingyas' preferences for the place of birth, but medical personnel do not consult them as they are considered illiterate. Home births and how the *fuwa dhoroni* navigates these events reflect refugees' flexibility, strategies and support networks. Chapter 8 is built upon the ethnographic material collected in the old camp, where I mainly conducted narrative interviews. Since institutions have obliged refugees to give birth in hospitals for more than a decade, most of the women are compliant to give birth in health facilities. The chapter presents a scenario of long-established policies that medicalise births. It also presents different perspectives of birth attendants who assist women in giving birth both in the camp and in surrounding villages. Finally, part two presents various dynamics of exclusion in the camps. Collecting ethnographic material is crucial not only for its lack in academia, but also to analyse the various approaches of Rohingya women to navigate labour and delivery.

Part three (chapters 9 - 10) – “Rohingyas' Ways to Navigate Labour and Delivery: Analysis of Survival Strategies, Forced Choices, and Adaptation” - lays the foundations to examine in detail three ways in which Rohingya mothers give birth in each of the camps. Chapter 9 examines multiple factors that affect Rohingyas' experiences in refugee camps, analysing the impact of national, global, and humanitarian discourses on birth. The chapter ends by analysing how these shifting rules in the camps have an impact on refugees. For instance, it analyses how the humanitarian discourse seeks to justify the poor inclusion of experienced Rohingya *dhoroni* from the health sector. Cultural, social, religious and political factors influence how Rohingyas wish to give birth, and this issue is approached from a different perspective in the following chapter. Chapter 10 examines Rohingyas' fears of hospital births, their wish to be accompanied by a *dhoroni* who can also take care of the interaction with medical personnel, and the relevance of respecting certain beliefs and practices during childbirth. *Šoril* or *ga*, (“body”), serves as an additional layer to analyse how multiple laws influence Rohingyas and their decisions regarding childbirth in the camps. In the informal settlement camp, an ever-growing number of Rohingya women give birth in the health facility as a “forced choice” due to the general camp rule of hospitalised births and the weakened bodies of Rohingya women. In the new camp, most women give birth at home as a survival strategy, while medicalised births in the old camp are more common because women have adapted after decades of life there. Through their bodies, Rohingyas make sense of their experiences and navigate each context in various ways or approaches.

Ultimately, this thesis reflects upon the dynamics of social exclusion, characterising a complex intertwining net of laws affecting Rohingya women, especially in the field of reproductive health and the intimate moment of giving birth. It attempts to assess the impact and extendibility of the present work and make sense of the strength of Rohingya women's ways to navigate the context of protracted displacement in the camps in Bangladesh.

6. Remarks

The present dissertation attempts to provide the reader with a novel analysis and interpretation of the experience of forced migration and social exclusion through the case of Bangladesh, the perspectives of Rohingya women and, in particular, birth attendants living in three different refugee camps. It combines contributions from legal anthropology with insights derived from anthropological refugee studies. These central approaches are based on a historical analysis and challenge conventional legal categories to prioritise social and medical anthropology analysis with a focus upon marginalised perspectives.

During my fieldwork, I noticed that the use of paperwork like the birth certificate is an instrument for authorities to control Rohingyas. For instance, women who in the camps give birth in their shelters do not receive a birth certificate for their children. Without this document there will be less resources for the family in terms of rights and services. Despite this, a large number of women continue to give birth at "home". How can this be explained and understood? What are the underlying social, cultural, political logics and representations of the various social actors?

Rather than focusing on the significance of "customs" and how Rohingya birth attendants traditionally "do things", this PhD thesis seeks to focus on the protective role that birth attendants — and the pregnant woman's acquaintances — offer during childbirth in the condition of social exclusion in refugee camps. Therefore, for certain women in the new camp, the body becomes the "only thing that is left" to them, and their survival strategies are one of the ways they have to navigate the situation in the camp. While this PhD dissertation aims to look for other answers, it also tackles broader questions by employing theories, concepts, and methods as defined in their dialogue with ethnography. This analysis undoubtedly also addresses notions of difference, otherness, and how people, especially women, make sense of these distinctions in everyday life.

CHAPTER 1 Methodology

The objective of this chapter is to, firstly, outline my understanding of a reflexive approach. Then, it describes the chronology of my fieldwork, information on the research participants, and the research methods, like participant observation and interviews. Finally, it delves into the challenges to access fieldwork.

1. A Reflexive Approach, the Role of Languages, Law and History

The anthropologist Rachelle Chadwick (2021), who has researched births in South Africa, describes her ambivalent position as “staying with discomfort”. She points out that many misunderstandings may emerge during fieldwork. They make it difficult for the anthropologist to develop a form of empathy with her research participants. On the contrary, Molly Fitzpatrick (2022) considers the overall discomfort emerging from the asymmetries of her fieldwork as a starting point. As a *doula*²⁷ and an anthropologist conducting research in a private clinic in Bali, Indonesia, she reflects actively on her position, and this enables her to establish intimate relationships with her research participants. The anthropologist Clémence Jullien also acknowledges in her analysis of social interactions with pregnant women in the public hospital of Jaipur, India, the discomfort she feels towards the hierarchical relations in that hospital (Jullien, 2019). In the attempt of being as aware as possible of this sense of awkwardness, which is an important debate in anthropology, but it acquires different nuances in the field of reproductive health, I have studied the relevant languages and terms for fieldwork. Besides, historical and legal analyses have supported my understanding of asymmetries while navigating the context of refugee camps in the Global South with a reflexive approach.

The notion of reflexivity involves questions on how my research participants perceived me, as well as my background knowledge on the region. In particular, when preparing for field research, I realised that I would have faced practical challenges, and I asked myself the question: How would I position myself as a white, non-Muslim, European, unmarried, and childless female researcher in the field? I found no immediate answer to this question during my ethnography, which I consider to be both a method to study Rohingyas in the context where they took shelter and the product in the form of this final thesis. I tried to engage with each piece of information collected like the places I lived in, my social

²⁷ An individual supporting a pregnant woman before, during and after her pregnancy (Fitzpatrick 2022, p. 39).

interactions, my appearance and crucial moments creating trust with my research participants.

Since the beginning of my preliminary research, I have stayed at the most affordable hotels in Cox's Bazar – the closest city to the refugee camps. Cox's Bazar is also a tourist destination. Since 2017, with the beginning of the Rohingya humanitarian response, the number of ecolodges and resorts has grown rapidly. So, my choice was taken for budgetary reasons, but also because I wanted to engage with local people rather than spend my time with expats working in humanitarian response. During my second preliminary research stay of a few weeks in 2021, I moved in with a local family in a village close to the camp area. I agreed to the plan of residing with this family, after the mediation of my Bangladeshi academic mentor Professor Nasir Uddin, with whom I had been in contact for my research visa. However, I soon realised that this would have not been a sustainable option for my budget. I had to pay a research assistant, as outlined in the next paragraphs, and prices have skyrocketed in the entire camp area due to the humanitarian response and the presence of international social actors. I stayed in this housing facility for only one month, without running water and unstable electricity, living with a 31-year-old woman and her family, with whom I got along very well. At the end of my stay, she did not want me to pay, but I moved anyway. I preferred to find a more affordable solution. At the beginning, I chose to stay in Cox's Bazar, where I shared a flat with a woman from the capital city, Dhaka. In this way, I could travel with my research assistant from Cox's Bazar to the camp area known as Kutupalong. Later, I moved to a shared flat in Ukhiya²⁸ - named Ukhiya *upajelā* or উপজেলা, a sub-district (Biswas, 2004, p. 407).²⁹ These experiences, along with spending most of my time with Chittagonian people or Chittaingas,³⁰ allowed me to engage more closely with the Rohingyas, given their familiarity with local customs.

Still, I felt shattered. The choice of Cox's Bazar as my residence and the camps as fieldwork sites created a profound divergence within me. When I finally received all the necessary documents from the appointed office of the Refugees Relief and Repatriation Response Commissioner (RRRC) in Cox's Bazar to visit the camps, I could go there during a specific timeframe, from 9 a.m. to 3:30 p.m. In the afternoon, I had to leave the camps and

²⁸ As detailed in the next paragraph, in June 2022, when I started working with the research assistant Dihan, who is originally from Chittagong, I decided to move with her to a flat in Ukhiya, which was closer to the camp area. After four months of daily bus travel, I found some relief in living closer to the camps. I stayed in the flat in Ukhiya until the end of my stay in November 2022.

²⁹ The term "division" indicates the first administrative level in Bangladesh, followed by জেলা, *jelā*, district, and উপজেলা, *upajelā*, subdistrict (Biswas, 2004, p. 407).

³⁰ চিটাইঙ্গা, Chittaingas, people from the Chittagong division.

my fieldwork was over for the day. While it seemed that I was engaging with a sort of “anthropology at home” because I could do research just from 9 a.m. to 3:30 p.m., I also struggled to feel at ease when I was not in the camps and spent time with my Chittagonian friends. Many came from other cities in the region and had other expectations on how to spend their weekends drinking alcohol and smoking – practices that are not common in their places of origin. Despite my initial scepticism, I also tried to spend some time with the so-called “expats” working for NGOs and the UN, but they also spent most of their free-time drinking. Both national and international people working in the humanitarian response experienced heavy workloads during the week, which they counterbalanced during the weekend with alcohol consumption. Moreover, I did not feel comfortable with the striking difference between humanitarian workers’, especially expats’ earnings and Rohingya volunteers’ compensation in the camps or the local wages. My “otherness” was almost constantly present, as every day, I felt immersed in different ways of perceiving the world, environments, mentalities, and behaviours. This helped me engage in the research while simultaneously attempting to distance myself from all these types of living, and the essence of my fieldwork was to grasp the distinctions between myself and “the other”.

The Rohingyas struggled to perceive me as a researcher with the same skin colour but different objectives from those of humanitarian social actors. They were patient with me and answered all my questions. It took some time for me to shed the role of the বিদেশী, *bidesi*, foreigner (Biswas, 2004, p. 758), as many children on the street often shouted at me. Some key moments aided me in establishing genuine relationships and friendships with research participants, although until the end of my fieldwork, I was referred to as in the Rohingya spelling *bideci* (Siddique Basu, 2018). An example of this clearly emerged during the conversations with the birth attendant Moriam in the old camp, as referred to in chapter 8.

I reflected on my appearance and on the idea of wearing a *burqa* or *hijab* in the camps. I have never worn a burqa during my camp visits, but I learned how to wrap a scarf around my head and conceal my hair. This allowed me to participate in religious functions, such as the তালিম, *talim*, education (Munira, 2012, p. 128), indicating a gathering in a separate part of the mosque where only women attend. I attempted to appear a bit less different and asked a research participant to pierce my nose in her shelter. I did not expect that she would be so proud of this shared moment. When Roshida, an older research participant, learned about my piercing, she celebrated me by saying that after having my nose pierced, my “face

became complete”.³¹ Moreover, I took part in two births at home and six in the hospital of the camps while engaging with the research participants. Over time, the focus of my research narrowed down, and I felt closer to people. I travelled daily to the camp area either by public bus or by CNG with local individuals and Rohingyas. While in the camps, I simply walked; I occasionally travelled to other camps by CNG or tom tom.³² All these experiences, like not having a private vehicle, helped me considerably. Rohingyas who saw me arriving on foot did not necessarily associate me with NGOs, also because, unlike humanitarian actors, I had nothing to give them. Furthermore, I wore the so-called “three-piece” - a typical Bangladeshi dress code called সালোয়ার-কামিজ, *shalwar-kamiz*, pants-tunic, a kind of dress and wide trousers. It is called “three-piece” as a scarf is normally also included. The few blouses I wore were sewn by a tailor from Kutupalong camp; as I often passed by his shop to visit some of my research participants, I bought two items there. Therefore, since I mostly wore a three-piece, some research participants initially thought that I was from Bangladesh. Last but not least, for the last six months of fieldwork, I rented a flat with my research assistant, Dihan, in Ukhiya. When my research participants asked me about where I lived, learning that I was staying in a common room or flat in the vicinity of the camps made them feel closer to my experience too.

My attempt has been to conduct ethnographic fieldwork, inspired by some of the most renowned anthropologists like Bronisław Malinowski, to pursue participant observation, reside with the individuals involved in the research, conduct fieldwork for over a year, learn the spoken language to converse and engage in the flow of everyday life (Malinowski, 1922, pp. 2-6). Before my fieldwork, I completed two years of study (2019 – 2021) of the “Bengali language” at INALCO (Institut National des Langues et Civilisations Orientales) in Paris. I studied Rohingya independently and with two teachers during my fieldwork. In the field, I listened daily to Rohingya while interacting with research participants, and after my fieldwork, I continued to attend online Rohingya classes for almost a year. I would like to continue studying the idiom, as I was still unable to independently lead a complex conversation or an interview. I dedicated my fieldwork to the improvement of my language skills since language is a mirror of society, it was the first step for me to approach fieldwork

³¹ Nose piercing is a tradition in this region, especially among Muslim women. When I pierced my nose, some female research participants, with an air of satisfaction, told me that I was ready to marry. However, piercing does not seem to have any direct connection to religion.

³² CNG stands for Compressed Natural Gas. Due to air pollution in the major cities of Bangladesh, CNG is considered as an ideal fuel. The acronym CNG also indicates auto rickshaws having compressed natural gas as source. Electric auto rickshaws are called tom tom. CNGs and tom tom are the most popular means of transport in Bangladesh.

from abroad and is also part of my analysis, as it is a key to explore people's culture and experiences. To comprehensively grasp the complexity of the everyday life that I observed in the refugee camps in Bangladesh language was not enough, and ethnographic fieldwork could not be just based on my sensitivity or research skills. For this reason, to expand on my competences already refined at the INALCO,³³ I conducted in-depth historical and legal analyses framing the causes of Rohingyas' forced migration, as well as the exclusionary discourses in which, as refugees in Asia, they happen to live today.

2. Chronology of my Fieldwork

In November 2019, I conducted my first preliminary visit to Chittagong and camp 14 (the camp is referred to as "Hakimpara", which is the name of the area). On that occasion, I entered Bangladesh on a tourist visa, and thanks to my local gatekeeper, Farhad Jaman Joni,³⁴ I was able to navigate the Refugee Relief and Repatriation Commissioner and other offices. I had to request a visitor allowance from the Refugee Relief and Repatriation Commissioner's office in Cox's Bazar to visit the school that Joni opened in camp 14, which allowed me to explore the camp area for the first time.³⁵ Hence, camp 14 is the first and only camp I visited during my first research trip in 2019. On the occasion, I also visited Chittagong City to gain a better understanding of this region, stayed in Cox's Bazar, and went to the southernmost part of the region, namely Teknaf (see the map³⁶ in image 1).

A couple of months later, the COVID-19 virus spread worldwide, and fieldwork opportunities were blocked for an unpredictable duration. Capturing the voices of Rohingya women in Bangladesh would not have been feasible through online interviews, as several research interlocutors had no access to the internet, although some contributions were made in this regard (Islam et al., 2022). At my University, I had to design a "plan B" in case my fieldwork in Bangladesh would not be possible. However, I remained convinced that ethnographic data collected in this region constitute high-priority material, not only for academic purposes but also for humanitarian agencies, which are rarely able to collect first-hand material from these settings for any extended period.

³³ During the first two years in Bengali at the INALCO, in addition to language courses, I attended an introductory course on history, colonial history, anthropology and geography of South Asia.

³⁴ A scholar from the University of Bath, named Fariba Alamgir, put me in contact with Joni.

³⁵ In 2022, the Refugee Relief and Repatriation Commissioner stopped issuing "visitor allowances" to the camps in case the applicants had entered Bangladesh on a tourist visa.

³⁶ I drew two maps; one of Cox's Bazar district and another of the Rakhine State in Myanmar to indicate the relevant locations. Besides, drawing these two maps allowed me further reflecting on some representational aspects of these regions.

In November 2021, I was finally able to visit the country again,³⁷ this time as part of my PhD programme and on a research visa for two months. There, I conducted a second preliminary study (in November and December 2021) due to the long gap following my first visit in 2019. During this period, while in contact with the Department of Anthropology at the University of Chittagong and with Professor Nasir Uddin (a requirement to apply for a research visa),³⁸ I worked mainly with a research assistant, an MA student in anthropology at the University of Chittagong, named Tonmoy Chowdhury.³⁹ Tonmoy collaborated with me again from February until May 2022 and introduced me to the camp settings. Without his support, I would not have been able to establish such close friendships with Rubina, Nasrin, Roshida, and many other research participants, as described throughout the following chapters. However, as soon as he was temporarily substituted (as he was involved in another research project) by a female student colleague, whom I will refer to as Dihan,⁴⁰ and subsequently, by a female interpreter, Umme Kulsum,⁴¹ discussions regarding birth practices became significantly more accessible.⁴² Thanks to Dihan and her determination, I was able to assist with two births at home, and with Umme Kulsum, I could collect life stories of Rohingya women living in the old camp and assist with other births in the hospitals. This dissertation is based on interviews and observations conducted in the camps during

³⁷ Initially, Bangladesh responded to the COVID-19 outbreak by implementing flight suspensions from certain countries and mandatory quarantine for incomers (Al Sattar et al., 2022). More specifically, the government has implemented lockdown three times: from 26th to 30th of March 2020, from 28th of June to 14th of July 2021, and from 23rd of July to 5th of August 2021 (Sohel et al., 2022). In November 2021, shortly after my departure to Bangladesh when the global situation seemed to improve, the Austrian Parliament decreed the beginning of a lockdown period (Murphy, 2021). Luckily, I had been able to leave just on time. Since January 2022, after a spike in COVID-19 cases and its multiplying variants in Bangladesh, the government of Bangladesh enforced new protocols, including the mandatory use of masks in public spaces, obligation of vaccination to access restaurants and other responses in the domain of education (Alam, 2022; The Daily Star, 2022). Despite these regulations, by showing a negative COVID-19 test at the immigration control at Dhaka airport in November 2021, and by getting an additional vaccination dose in Italy at the end of December 2021, I was able to enter the country. Besides, I did not encounter any strict implementation of the regulations in the area of my fieldwork. I always travelled by wearing a mask to go to the camps, looked for updated information on the rules to follow and respected national indications.

³⁸ To obtain the research visa, I was required to present a series of documents at the Embassy of Bangladesh, including a letter from my university and an invitation letter from a Bangladeshi university. In this regard, thanks to my supervisor Alexandra de Mersan, I communicated with Professor Nasir Uddin from the University of Chittagong, who graciously supported my request by providing the necessary letter and extending an invitation to visit the University of Chittagong during my fieldwork. Moreover, he facilitated my communication with two of the three research assistants who helped me during my fieldwork.

³⁹ He gave his consent to be mentioned here with his name.

⁴⁰ I will not refer to her full name, but will simply use her nickname, as I was unable to obtain her consent to be mentioned here.

⁴¹ She gave her consent to be mentioned here with her names.

⁴² During my fieldwork, Tonmoy Chowdhury and Dihan were Master's students in anthropology at the University of Chittagong. Umme Kulsum is a translator who graduated with a degree in English from the University of Chittagong and currently resides in Cox's Bazar. Respectively, Tonmoy assisted me from November 2021 to May 2022 and Dihan from May until July 2022. Umme helped me with translation from Rohingya to English from July to November 2022.

preliminary research in November and December 2021, and fieldwork between February and November 2022.⁴³

⁴³ I conducted fieldwork in 2022 thanks to the École Française d'Extrême Orient's (EFEO) scholarship.



Image 1: Map of Cox's Bazar district. ⁴⁴

⁴⁴ I drew the map of image 1, which is originally a *Travel guide map – Cox's Bazar – Bangladesh*. The map, designed for tourists, does not showcase any details on the camps, nor on the bordering regions like Rakhine State and Chittagong Hill Tracts. It removes these areas from the tourists' imaginary.

3. Research Participants: Marginalised but Multiple Perspectives

During my preliminary research, given that the government of Bangladesh prohibited the Rohingyas from residing in villages or towns outside the camps, my interest in connecting with Rohingya women living outside the camps was a significant challenge. Many Rohingyas outside the camps were hesitant to disclose their identities to strangers. At the end of my fieldwork, I could ultimately discuss with some Rohingya women living outside the camps in the area of Cox's Bazar and Ukhiya. However, for space and time reasons, I preferred not to analyse and present this data within the present PhD thesis. For this reason, this ethnographic study has explored other viewpoints in the refugee camps that remain marginalised. More specifically, engaging with Rohingya women and concentrating on the social group of birth attendants or *dhoroni* not only provided a novel perspective on birth, but it also offered a sound basis for accessing the community, given their role authority and their recognition within the Rohingyas. Moreover, as a female outsider accompanied by female research assistants, I could conduct research on a topic belonging to the female sphere. Birth opened up new insights into the social exclusion of Rohingya women.

I have dedicated myself to spending time with Rohingya women of different ages, including birth attendants, young mothers and older women, while getting to know them. I have been lucky enough that birth attendants would notify me before delivering a newborn at home. By contrast, others have not involved me in child deliveries because homebirth is not officially permitted in the camps. Most of the hospitals have given me space to conduct observations in their health facilities, and almost all pregnant women have allowed me in during their childbirths. To give an overview of the principal research participants in this PhD thesis, the roles that some research participants play, such as Fatima, Naslima and Rubina, are worth being explained. They are all Rohingyas: Fatima is a *dhoroni*, assisting women with home births, whereas Naslima and Rubina work in a camp hospital. While Naslima is a "traditional birth attendant", Rubina works as a "community health worker".

Humanitarian social actors used the term "traditional birth attendant" (TBA), which corresponds to the Rohingya terms *dhoroni* or *fuwa dhoroni*. The World Health Organisation (WHO), head of the health sector in the Rohingya humanitarian response in Bangladesh, defines traditional birth attendants as "a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other traditional birth attendants" (WHO, 1979, p. 7). The present work refers to the terms *dhoroni* or "birth attendant", instead of the most common terms in the medical discourse, since I consider these more accurate and respectful. This choice avoids the use

of the adjective “traditional”, given the marginal role that traditional knowledge has in the health facilities and in the medical discourse, but not among Rohingyas. The designation “community health workers” (CHW) refers to some Rohingyas employed at the camp primary health centres. Community health workers are defined by the WHO as “health care providers who live in the community they serve, and receive lower levels of formal education and training than professional health care workers such as nurses and doctors. This human resource group has enormous potential to extend health care services to vulnerable populations, such as communities living in remote areas and historically marginalised people, to provide for [un]met health needs in a culturally appropriate manner, improve access to services, address inequities in health status and improve health system performance and efficiency” (WHO, 2020, p. viii). Both acronyms, TBA and CHW, are utilised in the lexicon of global health policies and humanitarian reports. The designation “midwife” is reserved for trained birth attendants who operate within health facilities, and in this context of forced displacement, it only applies to Bangladeshi women or expats.

In the camps, I have neither encountered nor heard of any Rohingya midwives, making it improbable that such individuals existed within the camps. Officially, Rohingyas were not allowed to assist hospitalised births in the camps, and only midwives and doctors (mainly from Bangladesh) supported pregnant women. Nevertheless, in almost each camp there was a health facility with its own practice and also Rohingyas assisted pregnant women. Instead, in case of home births, all women available assisted the pregnant woman, including relatives, neighbours and the *fuwa dhoroni*. On such occasions, I observed different phases than the ones referred to in medical terminology.⁴⁵ For example, the expulsion of the foetus and the placenta should happen one after the other and, for Rohingyas, it is conceived as part of the same moment.

Fuwa dhoroni or *dhoroni*, TBA and CHW, as well as pregnant women, each play different roles in the birth process, and their perspectives highlight the diversity of their experiences. In the camps, I endeavoured to differentiate how I gained access to my research participants. On some occasions, I asked the Rohingya volunteers who collaborated with the “site management office” of the camp, which I had to visit when entering each camp for the first time (see “Negotiating access to the field” in this chapter), to introduce me to the community health workers or birth attendants of the camp (who are also volunteers

⁴⁵ In the medical discourse, labour might be defined according to its three stages, in which the first stage begins with labour until the cervix is fully thinned and dilatated – i.e., effacement. The second stage lasts until the delivery of the foetus, and the third phase is over once the placenta is delivered (Hutchison et al., 2023).

employed in another sector).⁴⁶ In contrast, on other occasions, I engaged in informal talks with pregnant women and elderly women whom I encountered while walking around the camps. These individuals introduced me to a birth attendant with whom they were acquainted. The most effective means of reaching a *dhoroni* was through word of mouth, as they were usually well-known in the area or the camp. Thus, individuals directly supporting the humanitarian response, along with those who were not involved at all in the response, participated in my research.

4. Fieldwork and Participant Observation in Refugee Camps, Rohingyas' "Homes" and Health Facilities

The decision to investigate women's accounts was consciously made to focus on the marginalised experiences of refugees, examining their lives in the camps and birthing practices to shed light on various forms of social exclusion. I conducted ethnographic fieldwork for a total of 12 months from 2021 to 2022, mainly at the two selected sites for fieldwork, namely Kutupalong and Nayapara, where I visited five camps. During the first months of fieldwork, I visited and travelled around the camps to understand the broader picture of the humanitarian Rohingya response. Out of the 34 camps,⁴⁷ which ones would I want to spend most of my time in? Why? I collected general information on five camps to grasp the diversity of Rohingyas' experience. However, this dissertation will present the information collected in three camps: the "informal settlement camp", the "old camp", and the "new camp".⁴⁸ For reasons of space and time, I will only mention some data collected in the other two camps, which I will refer to as the "Hindu camp" and the "model camp"; the latter's name referred to the fact that this was the only camp where international standards of humanitarian responses were respected. A minority of Hindu Rohingyas lived in the Hindu

⁴⁶ Rohingyas can work only as "volunteers" and not formally employable due to their unrecognised legal status.

⁴⁷ One camp was closed in 2022, leading to thirty-three camps. All the camps were assigned numbers and were sometimes identified by their location names, like camp 14 or Hakimpara camp. The institutions managing the humanitarian response divided each camp into blocks (labelled with a letter of the alphabet) and each block into sub-blocks.

⁴⁸ The names of the camps have been changed to prevent the tracking of the information analysed in the present work and to protect the confidentiality of the research participants.

camp, whereas the majority of research participants identified with the Muslim majority. There was a small Christian community among the Rohingyas as well. ⁴⁹

I engaged in everyday life activities with female Rohingyas, predominantly at “home”, namely in their shelters. I have never directly asked any of them about how they would describe the places they live in. Nevertheless, because some Rohingyas have been living in Bangladesh for more than thirty years, others for twenty and the majority for almost ten years, I use the word “home”. Last but not least, most of the time spent in their shelters felt particularly intimate in terms of the confidence in our conversations and tasks pursued together. Hence, while I used the word “shelter” mainly to emphasise the living conditions of general poverty and precarity in the refugee camps, the term “home” appeared more appropriate to describe the familiarity of the conversations and exchanges with the research participants.

I conducted different types of daily activities with Rohingyas in their homes, such as washing clothes, cooking, and working. These moments provided me with in-depth insights into life in the camps and how Rohingyas were excluded in some aspects of the camp life that were not usually mentioned during narrative interviews with the research participants. From the beginning, I had the opportunity to meet several Rohingya community health workers and birth attendants. Some of them approached me on the camp road, whereas others were employed in the field hospitals. Inspired by these encounters and having received approval from the health sector coordinator, ⁵⁰ I visited three primary health care centres (and the respective sexual and reproductive health wards) in the informal settlement camp, the old camp, and the new camp. There, I collected the data presented in this dissertation. I also occasionally visited other primary health care centres and field hospitals, as well as private hospitals outside the camp area. ⁵¹ At these three primary healthcare

⁴⁹ Hindu Rohingyas have been, for example, relocated by the Bangladeshi government to a separate area also designated as *Hindu para*, isolating them from the rest of the camps. In contrast, Christian Rohingyas were transferred in 2018 from one camp to a “transit camp”, which is typically a temporary holding place before relocating refugees to Bashan Char – island in the Bay of Bengal. In this situation, Christian Rohingyas have remained in the transit camp since then, while another group of Christians exists in a different camp but faces challenges (personal communication with P., 10 April 2022). In fact, Hindu and Christian Rohingyas also come from Rakhine State and speak the same language as the rest of Rohingyas.

⁵⁰ “Sexual Reproductive Health” services were provided in the camp primary health facilities and field hospitals, which were managed by World Health Organisation, head of the health sector.

⁵¹ There are different typologies of health facilities in the Rohingya camps; a total of 93 health posts, 46 primary health clinics and five field hospitals (Tabu, 2022, p. iv). Most camps have at least one 24/7 health facility, called a Primary Health Care Centre or clinic, where Sexual and Reproductive Health services are provided by Bangladeshi midwives. Besides, health posts are open during the day, where only “outdoor patients” are examined. The humanitarian response group these two under the same category of “primary health facilities”, whereas only specialised field hospitals are labelled as “secondary care facilities”.

centres, which I also refer to as “health facility” or “camp hospitals”, I observed how births took place and combined this data with the information collected at home.

I also spent time with my research participants while participating in two home births and six births in hospitals. I primarily collected ethnographic data on births at home and in the health facilities of the camps through participant observation. I consistently adhered to the guidance of Rohingya birth attendants and midwives and listened to pregnant women and their relatives. I observed and noted down in my field notes all occurrences and details that gained prominence during participant observation, as well as those topics that were highlighted either in the literature or during narrative interviews. Daily, I wrote in my field diary, which I analysed together with the interviews, along with the mentioned topics.

Last but not least, I was honoured to encounter and support a couple of Rohingya teachers who established private education courses in the camps. This became necessary as the government banned Rohingya children’s access to local schools in 2018, resulting in a lack of educational provision in the camps within the humanitarian response, which provides only two classes. To cover this gap, Rohingya teachers have offered a comprehensive curriculum to children in the camp. I endeavoured to contribute to these initiatives by teaching English classes once a week in different schools during my stay. I conceived this as a way to give something back to the people who contributed to the accomplishment of this project.

5. Collecting and Organising Data: Interviews

During my preliminary research stay, I encountered another interpretation of “interviews”. I could not easily connect with Rohingyas living outside the camps. So, my research assistant started planning many interviews to conduct daily with local people. I soon realised that he aimed to collect information without establishing a tie with the interviewees. I understood this different approach to research caused by the presence of numerous NGOs in this area, which have established themselves throughout and introduced the idea of “efficient research” without establishing a communication basis and reliable space for the interlocutors to talk and share their experiences. In November and December 2021, I spoke to various people on the outskirts of Cox’s Bazar and villages around the camp area. Thanks to these conversations, I was able to adapt my research to the unique circumstances of the

camps and gradually explained to my research assistant the type of interviews I aimed to conduct.⁵²

The findings presented in this thesis are based on the personal accounts of twenty-six women collected during narrative interviews, as well as numerous informal talks with various individuals in the camps. The sample included six pregnant women and new mothers (i.e., those in the first months after giving birth) from the informal settlement camp, eight women who have been living in the camp or in Bangladesh for two generations (primarily from the informal settlement camp and the old camp), and twelve *dhoroni* from the three camps, including those employed in the health facility as community health workers or birth attendants, as well as those who are not employed but continue to assist women with home deliveries. During our time together, I conversed with several research participants on different topics, including their migration experiences. Re-traumatisation could have been part of these life stories. To avoid this scenario, I consulted in-depth readings on migratory traumas (Fassin & Rechtman, 2009; Santone et al., 2010) as best practice for fieldwork. After being asked to share their experiences on certain topics, such as housekeeping, food collection, cooking, education, work, gardening, house construction, migration, and birth, many research participants expressed gratitude for discussing for the first time important life experiences, and engaging with me in narrative interviews.

For many research participants, it remained incomprehensible why I chose to stay away from my family for one year and travel far away for “research purposes”, as I always explained to them. At the beginning of each interview, I verbally informed all research participants about my research and its objectives, and they agreed to participate. I told them that I was conducting a PhD research project at the University of Vienna, which is a study programme aimed at training me to collect information on the lifestyle and birth practices in the camps, as this was my primary interest. Almost all interviews have been audio-recorded and transcribed verbatim during and after my fieldwork. I collected the research participants’ approval orally to participate in the interview. In instances where research participants did not want to have their voices recorded, I did not use the recorder and instead asked them if I could take written notes. No one declined this option.

⁵² *The Code of Conduct of the University of Vienna* (University of Vienna, 2013) and the *Ethical Guidelines for Good Research Practice* by the Association of Social Anthropologists and Refugee Studies Centre (Refugee Studies Centre & Association of Social Anthropology, 2007) informed the ethics underlying this project. I regularly visited the research participants after conducting the interviews to ensure they could withdraw their involvement if they wished. The anonymity of research participants is maintained, which is crucial due to the sensitivity of the data. Both interlocutors and research sites are kept anonymous.

In the first four months of my fieldwork, I primarily collected life stories, particularly from the elderly research participants to reconstruct the history of the camps, informal settlements, and reproductive policies throughout the years. In a later phase, I conducted narrative and group interviews with Rohingya birth attendants, community health workers, pregnant women, and elderly refugee women regarding their everyday dwelling practices, community and family lives, births, forms of exclusion, and past events. Before conducting these interviews, I sought to establish a relationship through several encounters and clearly explained the objectives of the research. I brought a small gift (e.g., cakes, biscuits, dates, dried fish) to each research participant, who, in any case, offered food and coffee to me while sitting at their place. Even if they did not have much, they always ensured that I felt welcome. Apart from this one present, I had nothing to offer them; however, I continued to visit them regularly and endeavoured to achieve a level of confidence sufficient to discuss sensitive topics, hence the multiple visits.

During the only group interview with community health workers at a hospital, I had the impression that the research participants could open up more easily. However, the final result was that only two or three people actually spoke, while the rest did not actively share their opinions. In the last three months spent in the camps, I conducted semi-structured interviews with Rohingya birth attendants and community health workers in order to better understand their tasks, interactions with Bangladeshi midwives, pregnant women, and NGOs, as well as their training and practices.

Due to security restrictions in the old camp, I concentrated mainly on people's stories of their migration and past events. Therefore, through case-reconstructive research and the case-study method, partners were asked about a set of events from the recent past for the reconstruction of contemporary experiences (Gingrich, 1997; Verdirame & Harrell-Bond, 2005, p. 11). In this way, I investigated historical instances of Rohingya migration. It was useful to mention well-known events, such as the 1991 cyclone, the repatriations, and the resettlement programmes, in order to discuss their past experiences of migration during that period. Generally, referring to specific instances in the past like natural catastrophes is a research strategy that warrants further exploration in this context in case research participants have a different temporal understanding than the researcher.

A research assistant was always present to translate from Rohingya to English (and occasionally to Bangladeshi). Tonmoy assisted me in transcribing the answers in Rohingya during the initial interviews I conducted with him. For the remainder of the interviews, I was only able to transcribe the English parts of the interviews, as Dihan and Umme were no

longer involved in this project at the time of the transcription. After returning from fieldwork, I codified my field notes thematically and analysed the narrative interviews in relation to the relevant coding.

I conducted expert interviews with medical personnel, both international and national stakeholders. However, these interviews were not particularly successful in reconstructing past migration policies. In fact, very few individuals knew about the chronological development of Rohingya migration and related policies – yet they could provide technical information on the humanitarian response.

6. Negotiating Access to Fieldwork

During the preliminary research in 2021, I decided to change the focus of my research and work with Rohingyas in the camps. I sought permission from the Refugee Relief and Repatriation Commissioner and was granted access to visit two camps for a few days in December 2021. For the remainder of my research stay, I spoke to and interviewed local people with the help of Tonmoy Chowdhury, as mentioned in the section on interviews. Over time, I established contact with Rohingyas residing in villages, from whom I collected data excluded from the present study for reasons of space and coherence.

I returned to Bangladesh in February 2022 with a renewed research visa for four months. Four months later, I had to leave the country but could reuse the visa for another four months. For the last month of my fieldwork in November, I decided to stay on a tourist visa while interviewing and conversing with Rohingyas living outside the camps instead of flying back to Austria to apply for another research visa. In general, the research visa facilitated my access to formal documentation, such as the Refugee Relief and Repatriation Commissioner's permission to conduct research in the camps. However, it affected my time management, as every four months, I had to leave the country.

In February 2022, I applied for a one-year camp pass at the designated Refugee Relief and Repatriation Commissioner's office. The office issued a two-month pass that had to be renewed periodically, allowing me to conduct research under certain conditions.⁵³ The Refugee Relief and Repatriation Commissioner granted me this pass in part due to my research focus on births and birth attendants and the perception that my work with women seemed less than important from their institutional perspective. By the end of my fieldwork, I was able to investigate issues regarding how dynamics of control were exerted on women's

⁵³ These conditions are explained in the next paragraph and were enlisted in the office's permission (as shown in Annex I).

bodies and exclusion during childbirth. I was not explicitly allowed to take pictures in the camps. For this reason, I have not used any photographs taken in the public spaces of the camps. Moreover, to keep my research participants anonymous, I decided not to include any photos where people's faces are recognisable. Instead, I drew some images to still provide the readers with a visual depiction of my fieldwork, research participants, and their documents. I also drew two maps to highlight some of the relevant locations.

In each camp, I routinely attended the “site management office”, which was second in the camp hierarchy only to the “camp-in-charge” person. These visits enabled me to gather general information about the camp, its organisational structure, and the humanitarian response. At the onset of fieldwork, visiting a new camp entailed registering a substantial amount of information concerning the camp populations, rules, and characteristics, as well as approaching the camp-in-charge person, namely the administrative representative of the government.

Furthermore, external visitors, including myself, were permitted to visit the camps only during the operational hours of the NGOs, specifically from Sunday to Thursday, 9 a.m. to 3:30 p.m.⁵⁴ I was not allowed to sleep over in the camps but was invited to several events, such as marriages, that took place on the weekends when I could not visit the camps. The Refugee Relief and Repatriation Commissioner permitted me to operate in all camps under the stipulation that inquiries regarding the interaction between Rohingyas and local people would not be entertained. Given these settings, the camps selected are both in densely populated areas near other camps and in remote locations. Additionally, I chose to conduct my fieldwork in camps inhabited exclusively by Rohingyas and others where both local Bangladeshi people and Rohingyas resided. Inevitably, not all intentions I had were successful. These criteria influenced my choice to work on and analyse the informal settlement camp (which used to be a makeshift settlement before 2017), the old camp (established in 1991-1992), and the new camp (opened in 2017). Notwithstanding my objective to achieve a balance in the research of both UNHCR and IOM camps, all of which are located in the southern region of the Division of Chittagong⁵⁵ (as indicated in red on the first map of the country in image 2), I could not fulfil this objective. Indeed, the camps analysed in this work were managed by the UNHCR. This decision provided a valuable basis for comparison, as one camp was administered by BRAC⁵⁶ (delegated by UNHCR), another

⁵⁴ Sunday is the first day of the week in Bangladesh, and weekend starts on Friday.

⁵⁵ The first level of administration in Bangladesh is called a “division”. There are eight divisions named after the largest cities. Each division is classified into smaller “districts”, which are further divided into *upajelā* and “union councils”, as already mentioned.

⁵⁶ See footnote 8 for the initial spelling of BRAC.

UNHCR camp, and an older facility were directly overseen by ActionAid. Furthermore, I must emphasise that the absence of IOM camps in this study was due to the significant challenges I faced in accessing these camps. The IOM site management often proved uncooperative in sharing even basic information about the camps, and the staff motivated this negative

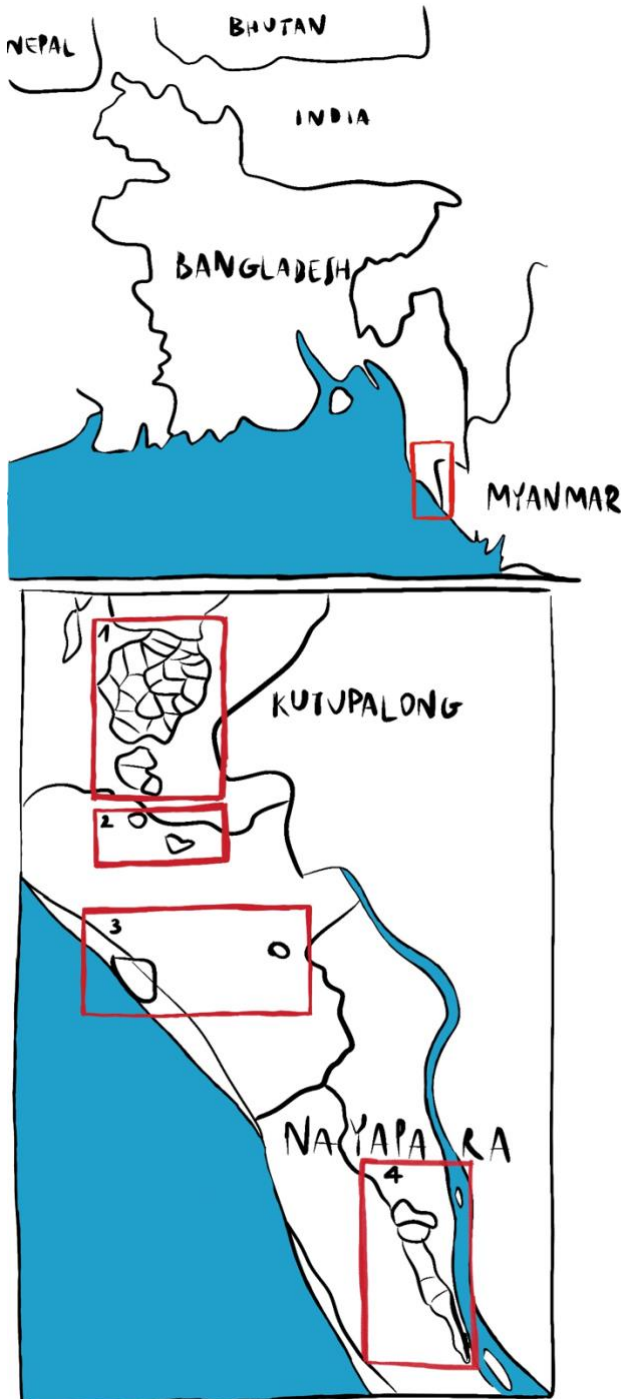


Image 2: The first map of Bangladesh shows Southern Chittagong. The second map shows the region and in four red frames cluster no. 1 of camps (Kutupalong and another area, called Balukhali), camp areas no. 2, 3 and 4 (Nayapara area).

response by pointing to the general IOM policy. The difference in approaches between the UNHCR and the IOM was also evident in other examples, such as the Bashan Char initiative, to which the IOM has refused to participate. In contrast, the UNHCR implemented the resettlement of Rohingyas to the island and provided all services there. The reason for this contrast could be explained by the IOM's relatively new role in the United Nations system. In 2016, the IOM became a United Nations-related organisation and this could have influenced its policy towards granting access to researchers or collaborating with foreign governments on contested projects like the one of Bashan Char. Sporadically, I interacted with some refugees living in the IOM camps. This slowed down data collection and, in general, did not create a welcoming atmosphere for me to conduct research in these particular camps.

Temporal and spatial criteria guided my selection of the camps for the current research. In this way, a diverse group of Rohingyas contributed to my fieldwork; those who fled to Bangladesh at different times (i.e., in 1978, 1991-1992, 2012, and 2016-2017) and lived in the Kutupalong area (cluster no. 1 of camps in the second map of image 2), as well as in the southern districts.

7. Concluding Remarks

A reflexive approach helped me pursue ethnographic research, conduct qualitative research and interact with research participants in such a new context. Actively reflecting on my position and the choices I made during my everyday life in the field were essential steps for a clear focus on my research and methods. Besides, I reflected on my appearance and language, whether it was the official Bangladeshi, Chittagonian or Rohingya local idioms. After my preliminary stay and the beginning of my fieldwork, I started to grasp the nuances of birth. Rohingyas' discussions around birth were not included in humanitarian reports, but were equally important in order to narrow down my research focus and understand women's point of view. As a sideline, historical and legal analyses were essential for a basic understanding of the region. At the beginning of my fieldwork, I tried to disentangle the history of camps. The work in camps was restricted in terms of given timeframes in which I could enter them (from 9 a.m. to 3:30 p.m.), and this felt sometimes like conducting anthropology at home. Moreover, restrictions of movement in the old camp led me to collect life stories through narrative interviews, while I could not conduct participant observation during childbirth. To gain access to fieldwork I had to be allowed by the Refugee Relief and Repatriation office. Narrative interviews of pregnant women or new mothers, as well as birth attendants and other women directed my comprehension of the field. I described how I conducted the interviews and analysed them: I explored the narratives of mothers, and then during semi-structured interviews the expertise of birth attendants. Furthermore, participant observation meant for me to take part in everyday life activities at home with Rohingya women. Soon, I moved to three primary health centres as well, where I could observe practices linked to Rohingya community health workers and birth attendants. I observed hospitalised births or other deliveries at home with an eye for details that anthropologists have when taking fieldnotes, conducting interviews and participating while observing.

PART ONE. HISTORICAL AND LEGAL DISCOURSES ON THE FORCED
MIGRATION OF ROHINGYAS TO AND IN BANGLADESH

CHAPTER TWO Basic Historical Dimensions on Arakan and Rohingya Migration

Paula Banerjee and Ranabir Samaddar, both renowned Indian scholars and vice-chancellor and director of the Calcutta Research Group, ⁵⁷ propose the definition of “forced migration” to underline the importance of historical processes when examining how differences have been managed in Asia. Focusing on certain historical events is crucial for addressing present social dynamics and political outcomes. The Indian scholars argue that the criminalisation of certain sections of the population during and after partition stemmed from the colonial period but was often reinforced during the process of nation-building (Banerjee & Samaddar, 2019, p. 54). Towards the end of colonial rule in Burma, ⁵⁸ anti-communal riots occurred against Indians and other minorities. These episodes are part of longer processes, which are relevant for examining more recent Rohingya forced migration.

This chapter aims to show that Rohingya migration has a long history in Arakan, whereas their forced displacement is relatively recent. Before the creation of new nation-states like Myanmar or Bangladesh, people moved and circulated in the region on a regular basis. In this context of movements and exchanges, any attempt of the colonial administration to identify ethnic groups as distinct entities has been deemed a failure. Likewise, the debate around the ethnogenesis of Rohingyas before or after the colonial rule is limited in its purpose, as people in this borderland have been in continuous contact and exchange with each other. However, the heated discussion around the name of Rohingyas and their origins reflects the complexity of events that contributed to their forced displacement. In other words, this chapter argues that the debate around Rohingyas and their name is so complex because several historical events contributed to their forced displacement. Before addressing Rohingya migration in terms of “forced displacement or forced migration”, this chapter tackles specific historical events, such as, the resettlement of people across various regions and census activities during the colonial period, the years before and after the partition *stricto sensu*, ⁵⁹ the establishment of a new nation-state, the diffusion of nationalist

⁵⁷ Founded in support of the peace movement in West Bengal, the Calcutta Research Group is known for its research and advocacy work (see its website at: www.mcrg.ac.in).

⁵⁸ In colonial times and until 1989, Myanmar was referred to as “Burma”. “Arakan” used to be the name of the region that in 1982 was renamed Rakhine State. Prior to its independence in 1971, Bangladesh was called East Pakistan. These terms will be used solely due to historical accuracy.

⁵⁹ The term “partition” *stricto sensu* pertains 1947 British India’s fragmentation into the Union of India and the Dominion of Pakistan after the Indian Independence Act.

discourses and the introduction of borders, which have led to a tense situation in Arakan and later to the forced migration of Rohingyas.

1. Rohingyas and Their Name

Who are the Rohingyas? The debate examining the origins of this designation is important because it shows the various names that, throughout the years, have been used to indicate a heterogeneous group of people. Besides, it intertwines with the more recent struggle of the Rohingyas in having their citizenship and identity acknowledged in Myanmar. Moreover, this debate shows that the attempt to name people according to a strict definition of ethnicity mixed up with the colonial understanding of the region. Last but not least, it showcases that diverse forces and historical circumstances have intertwined and contributed to the current condition of displacement for Rohingyas. “Rohingya” currently encompasses all Muslims, along with a minority of Hindus and Christians ⁶⁰ from Rakhine State living along the Burmese west coast. The term is employed by refugees from Myanmar, primarily living in Bangladesh, but also by smaller communities in India, Indonesia, Malaysia, and Thailand. Others have settled in Saudi Arabia, Pakistan, and some Western countries.

Several scholars have begun their academic contributions on the name “Rohingya” by citing Francis Buchanan’s text to demonstrate that the designation was already circulating at the end of the 18th century and that the Rohingyas belong to Rakhine State (Chaudhury & Samaddar, 2018; Uddin, 2020). Besides agreeing with them, I argue that the information left by Francis Buchanan ⁶¹ could be used to highlight other important aspects. The term “Rohingya” was first noted in 1795 by British physician Francis Buchanan, who described the “Mohammedans in Arakan” as identifying as *Rooinga* (Buchanan, 1799). More specifically, the British physician referred to *rooinga* by indicating their elevated status and three dialects; one “spoken by the Mohammedans, who have long settled in Arakan, and who call themselves *Rooinga*, or natives of Arakan. The second dialect is that spoken by the Hindus of Arakan. I procured it from a Brahmen” (Buchanan, 1798, p. 237). Hence, as

⁶⁰ Christian and Hindu Rohingyas are rarely included in the media representations of Rohingyas. Christian Rohingyas manifested their preoccupation of not being accepted as Rohingyas by the remaining Muslim Rohingyas and of being discriminated within the camps in Bangladesh (personal communication with P., 10 April 2022), whereas Hindu Rohingyas never talked about this issue with me, although some were harassed by other Rohingyas.

⁶¹ Dr. Francis Buchanan, born in Scotland in 1762, qualified as a medical doctor in 1783. He travelled to the West Indies as a ship’s surgeon before being stationed in Bengal. In 1795, he served as the surgeon for Captain Michael Symes’ Embassy to Ava, the main city of Burma at the time. Later, he changed his name to Hamilton and is often referred to as Buchanan-Hamilton. He collected extensive information on Burma and the Andamans (van Schendel, 1992).

emphasised in Alexandra De Mersan's (2019) analysis of Buchanan's text and of other ethnonyms used in the region, there is no clear-cut separation between Hindu and Muslim, and the people referred to as *rooinga* hold a high status, i.e., "Brahmen". Historian Jacques Leider and specialist of Bengal and Bengali literature Thibaut d'Hubert have focused on groups of people who acted as an interface between local power and the outside world at the cosmopolitan court of Mrauk U in Arakan (Leider & d'Hubert, 2011, p. 91). During the Kingdom of Mrauk U (1430-1785), the king of Arakan leveraged his naval strength to capture many people in Bengal and, when these were not sold as slaves, the Hindu and Muslim Bengalis were settled as royal workers (*lamaing*) in the rice-growing plains of the Kaladan and Lemro rivers (Leider & d'Hubert, 2011, p. 87). Those associated with a social group of specialists were referred to as *yakhine kala*: Muslims and Hindus who were kept at court, composing poems and enriching Bengali literature (De Mersan, 2019, pp. 8, 15). Other scholars identified the word Rohingyas as deriving from *Rohang*, the original name of the region of Arakan (Chaudhury & Samaddar, 2018, p. 6; Uddin, 2020, p. 30). They agreed that the Rohingyas developed from many stocks of people during the dynasty of Mrauk U. To sum up, most designations appeared to be used for heterogeneous social groups of people, and Arakanese culture had been influenced in multiple ways, including the presence of slaves from other regions. On this last point, historian Bryce Beemer has reached important conclusions through his work on mainland Southeast Asia, Northeast India and coastal Bengal. He has demonstrated that the practice of enslaving artisans and other intellectuals in the late 18th and 19th centuries has contributed to a consistent cultural exchange in the region (Beemer, 2016). Other ethnonyms from similar periods have emerged from different contexts. The term *kala*⁶² referred to people from the West, who were often captured in Bengal and sold into slavery to the Dutch or subjected to forced labour in rice production within the Kingdom of Arakan. The *kala* played a role in Arakanese society according to their occupations or relations with the authorities (De Mersan, 2019, pp. 8, 10). The various ethnonyms have showed not only the Muslim presence in the region prior to the British domination – which nationalist discourses have recently challenged - but also the heterogeneous social composition of Arakan.

This section has presented a condensed version of the broader debate around Rohingyas' name to highlight useful details on the composition of Arakan, where many exchanges have contributed to the formation of Arakanese culture in precolonial times.

⁶² In contemporary usage, *kala* has gained a derogatory meaning, frequently employed in Rakhine State to demean Muslims (de Mersan, 2016, p. 129).

Furthermore, it has the function of laying the grounds for the remaining historical chapter focusing on the various factors that have contributed to the recent persecution and forced migration of Rohingyas. As the next section attempts to show, two aspects have influenced considerably the demographic composition in Arakan in the colonial period. Following the first Anglo-Burmese War in 1825 and the annexation of Arakan to the British Empire, firstly, large-scale Indian migration to Arakan was promoted (Chaudhury & Samaddar, 2018, p. 6; Uddin, 2020, p. 34).⁶³ Colonial authorities implemented the migration of people from today's India to Arakan, enhancing the already diverse demography of the region. Migration occurred, for instance, from Chittagong and other regions as well. Secondly, the term Rohingya was not used as an ethnic classification by the colonial administration until the late 1940s (De Mersan, 2019, p. 15). However, the colonial administration used censuses in Burma and referred to caste, religion, language and birthmarks to introduce boundaries and construct ethnic groups in a very diverse demographic context. Later, the post-colonial regimes subsumed ethnic differentiation under civic identities without acknowledging that ethnicity remains mutable among various Myanmar ethnicities and elsewhere (Prasse-Freeman, 2017, p. 2).

2. Colonial Period in Arakan

Providing a concise yet well-articulated historical account of the colonial period in this border region is no small undertaking. Moreover, given the heated debates surrounding the term “Rohingya”, the choice of sources becomes even more politically charged than usual.⁶⁴ ⁶⁵

Before any formal colonial enterprise, social contexts in Arakan appeared quite diverse. In 1784, the East India Company established the first division between Chittagong and Arakan, when it annexed the former. Arakan became part of the “British Indian Empire”

⁶³ The British Empire colonised Burma in three phases: 1824-1826, 1852, 1885-1886, which correspond to the three Anglo-Burmese Wars.

⁶⁴ In 2015, Nay San Lwin, a prominent Rohingya political activist, together with scholars and rights campaigners, initiated a petition against commissioning *The Oxford Research Encyclopedias* to Dr Jacques Leider, head of the Bangkok and Yangon-based École Française de l'Extrême-Orient (EFEO), to write an article about the Rohingya people. While I agree with the petitioners that some of Leider's opinions seemed controversial, particularly his views on the concept of ethnicity and the claims regarding Rohingyas (see, for example interview with Jacques Leider, at: <https://danyawadi.wordpress.com/2017/09/02/interview-with-rakhine-history-expert-on-the-recent-communal-conflict-in-rakhinestate/>), I believe that his contribution to the region's history is unique. His work has been crucial for my analysis, especially in relation to Rohingyas and their forced migration. For a general overview of the history of the country, instead, the work of Michael Charney has been a central reading for me.

⁶⁵ This chapter has been informed by the works of both Western and Asian historians – available at the Vienna libraries - like Willem van Schendel, Michael Charney, Jacques Leider, John Cady, Sunil Armith, Moshe Yegar, Rajashree Mazumder and Cheng Siok Hwa.

in 1825 (Cady, 1960, p. 67). At that time, Buddhist farmers from southern Arakan lived alongside Muslims, including seasonal migrants from Chittagong and other areas, as well as some Muslim residents who had already settled there prior to British colonisation. The presence of the British Indian Empire in Burma officially began with the three Anglo-Burmese Wars. In 1825, following the first Anglo-Burmese War, the British East India Company annexed the Burmese regions of Arakan, Tenasserim, and Pegu (Cady, 1960, p. 74). In 1858, the British Raj was instituted and with it an administrative system that operated at four local levels that substituted the posts held by Europeans (Cady, 1960, pp. 90-93). Already in 1885, the British conquered the entire territory of Burma, making the migration or the presence of Chittagonians in Arakan less prominent debates compared to previous decades, as there was no formal division anymore separating the East India Company from the rest of Burma. From the 1860s to the 1930s, North Arakan witnessed a steady influx of cultivators from Chittagong settling in the region (Leider, 2023, p. 253), particularly following the second and third Anglo-Burmese Wars and the British occupation of the whole country in 1885 (Mazumder, 2019, p. 16). Nevertheless, around this time, the East India Company militarised Arakan due to its geopolitical significance - in 1852 the capital of Arakan was the first city to export rice in the world (Cady, 1960, p. 86)- and secured the border for economic and military reasons (Mazumder, 2019, pp. 1156, 1159).

According to the “Bengali Immigration Scheme”, introduced in 1874, the colonisers began to formally endorse migration from Bengal to the coast of Arakan, Irrawaddy, Pegu and Tenasserim to make profits from their labour force.⁶⁶ As a response to the lack of success of this policy, the colonial administration reacted by sponsoring a similar migration scheme from Madras, Indian region. The first group of migrants left Madras in December 1877, and the migration programme lasted until March 1878 (Siok Hwa, 2012, p. 119). Once again, this policy resulted in failure; migrants did not remain as long as the colonisers had wished. Another migration route was used by those coming from Chittagong, who arrived on foot in the district of Akyab in Arakan and returned by boat (Siok Hwa, 2012, p. 123).⁶⁷ Most people, also known as *coolies*, came from Madras and Bengal staying as seasonal workers (Siok Hwa, 2012, p. 120). According to some colonial reports, their rotation took place twice a year, following the rhythms of the rice harvest calendar, whereas others

⁶⁶ A few years later, millions of people in the region died during the Great Famine of 1876-1878. Famine and especially the diffusion of diseases in the Indian Ocean World are analysed in connection to social upheaval, transformations and colonialism in the volume *Disease Dispersion and Impact in the Indian Ocean World* (Knoll & Campbell, 2020).

⁶⁷ More details in the book *The rice industry in Burma, 1852-1940* by Cheng Siok Hwa, faculty member at the Department of History at the National University of Singapore.

worked in rice mills or in commercial occupations (Siok Hwa, 2012, p. 123). The history of shared experiences, the proximity of the region of Chittagong and cultural exchanges, coupled with the availability of work and food in Arakan, as pointed out in the book *A History of Modern Burma*, attracted many migrants from Chittagong (Cady, 1960, pp. 41, 42). The proximity with the neighbouring region of Chittagong was not only geographical, especially when the Kingdom of Arakan seized southern Chittagong in the mid-15th century. The Kingdom of Arakan conquered southern Chittagong and maintained a stable rule through its naval force until 1666 (Leider & d'Hubert, 2011, pp. 80; 86). Generally speaking, people from Chittagong and elsewhere provided the labour force for the colonial development of the region (Mazumder, 2019, p. 1157).⁶⁸

The colonial administration used to conduct population censuses, and their presence in Arakan was tangible in the way differences began to be managed. Before the Bengali Immigration Scheme, many Muslims and Buddhists had been living in Arakan as early as 1852 (Cady, 1960, p. 85). Besides, the historian Michael Charney⁶⁹ has emphasised that many migrant individuals were essentially indistinguishable from the Burmese (Charney, 2009, p. 9). This confirms once again that even prior to the colonial migration policies supporting the settlement of Indians in Arakan, Muslims were already residing in the region. Some of them lived in Burma for so long time that they were considered indigenous people (Siok Hwa, 2012, p. 265). Moreover, distinctions between Burmese and non-Burmese people could not easily be drawn, partly because Muslim men tended to settle in larger numbers compared to Hindus,⁷⁰ for example, as Islam permitted them to marry local women. In case of some Buddhist women who would convert to Islam to marry Muslim men, as the historian Mohammad Zahidur Rahman from the University of Chittagong has pointed out (Rahman, 2020, p. 314), their children were called *Zerbadee* (Yegar, 1972, p. 33). In this context, the colonial administration that differentiated the population primarily based on the majority and minority religions brought a lot of misunderstandings. While colonial reports mentioned the Chittagonian migration supporting the harvesting cycle in Arakan, it was not until 1921 and 1931 that they distinguished the members of the old Muslim community, referred to as “Arakanese Mahomedans” or “Indigenous Mahomedans”, from Chittagonians (Leider, 2018, p. 6; Leider, 2023, p. 353) and other incoming migrants (De Mersan, 2019, p.

⁶⁸ Programmes of mass scale labour migration in the colonial domains were no Burmese exception, but part of wider British colonial schemes in Asia, including today's states of Malaysia and Singapore.

⁶⁹ Myanmar specialist and Professor of Asian and Military History at the School of Oriental and African Studies (SOAS), at the University of London.

⁷⁰ I assume that the Bengali immigration schemes might explain the presence of a small group of Hindu Rohingyas.

29). This has already caused some confusion because it did not differentiate between the various Muslim groups. Furthermore, colonial authorities did not officially regard Muslims as part of the Arakanese identity, which was upheld as Buddhist, and the ancient Arakanese Muslims were merged with Indian groups without considering their actual ancestry (De Mersan, 2019, p. 26).

Census activities were conducted in a way that indexed information regarding religion, ethnicity, language, and other identification factors through a very narrow and rigid framework, not allowing any room for overlap and fluidity (Charney, 2009, p. 9), and using a markedly Eurocentric perspective. Similar to other regions in Asia, the colonisers promoted the narrative that Muslim workers were more disciplined than their Buddhist counterparts (Mazumder, 2019, p. 14). This was part and parcel of their backbone colonial policy of *divide et impera*. During the colonial period, the administration created and enforced social divisions without regard for the regional context by introducing a strict definition of ethnicity through the census, alongside the policy of *divide et impera*. In these settings, Charney (2009) referred to the image of a “colony within another colony” ⁷¹ meaning that, during colonial times, Burma was dominated not only by British rulers but also as part of India within a hierarchy that permeated the region. The tense relations between the people of Burma and both the colonisers and the Indians were further exacerbated by a lack of nuance in colonial processes. For instance, most colonial officers in Burma did not possess any basic command of the Burmese language. The lingua franca in the region was set as Hindi-Urdu or Hindustani (Cady, 1960, p. 85), and most officers never bothered to learn Burmese. These tensions escalated at the end of the colonial rule.

3. The “Partition Process” in Burma and the Border in Arakan

I refer to the “partition process” to indicate the long-term process that unfolded in the region over decades and led to the dissolution of the Indian British Empire in three phases. Historian van Schendel (2005) expands on this point of view and identifies three moments to define the dismantling of British India. a) The creation of a separate colonial state of British Burma in 1937; b. the “Partition *stricto sensu*” of 1947 and the creation of two new states

⁷¹ Scholars like Bowser talk of “co-colonialism” to refer to non-European people who become colonisers themselves (Bowser, 2021, p. 120).

divided on the basis of religion;⁷² and c. the dissolution of the state of Pakistan into Bangladesh and Pakistan in 1971 (van Schendel, 2005, p. 27).

In 1937, Burma was officially separated from India as a distinct British colonial entity, and the idea of “notional boundary” was introduced to prepare local populations for national divisions (van Schendel, 2005, p. 48). Based on the demarcations of the Simon Commission, the border between Burma and India was drawn. Certain territories were divided despite lacking any history of prior separation like Arakan and Chittagong, where the Simon Commission established a long “natural” line between “Indian and Burmese races” (De Mersan, 2019, p. 28).⁷³ Border regions and their inhabitants struggled with this idea because they could not carry out ordinary activities across the newly established borders anymore, and did not envision statehood territorially (van Schendel, 2005, pp. 136, 137). What had been an internal administrative border within the colonial territory became a politicised border in 1937 between two distinct colonial entities.

An international border was introduced to separate the Burmese and Indian provinces, and this marked the beginning of a new transitional phase, as well as the increase of tensions in the region. Between 1937 and 1942, Burma was not independent yet, but had limited self-rule (Charney, 2009, p. 71). This formal beginning of what later became conspicuous as the overall partition process impacted the regional context of Arakan and Rohingyas in various ways.

Firstly, the sudden shift in policies from a supportive stance of migration to restrictions around this border led to drastic changes (Amrith, 2015, p. 217). Cross-border activities were no longer accepted, cross-border marriages were overlooked, and the separation of families took place anyway (van Schendel, 2005, p. 343). In this context, the logic of differentiation and self-identification became particularly significant in border regions. For instance, in the 1940s, the spelling *Rwangya* was adopted in Arakan to distinguish the old Muslims from the later migrants from East Pakistan, present-day Bangladesh (Leider, 2018, p. 9).

On a political level, secondly, migration became associated with the narrative of invasion within the country. Van Schendel used similar terms to explain the post-partition scenario in India, with his image illustrating a signboard that clearly reflected the political narrative of migration in terms of invasion (van Schendel, 2005, p. 191). In Burma strong

⁷² India maintained a prominent position in Burma even in the aftermath of debates surrounding partition (Charney, 2009, pp. 40, 41), and for this reason, partition studies essentialise the partition as the moment of India’s division in 1947 (which in this doctoral thesis is referred to as partition *stricto sensu*).

⁷³ After WWII, this division will correspond to the geopolitical blocs of South Asia and Southeast Asia (van Schendel, 2005).

feelings of anxiety targeted minorities as “foreigners”. During these initial phases of nation-building process in Burma, individuals from colonial India were depicted as infiltrators, threatening the future of the Burmese proto-nation state (van Schendel, 2005, p. 201). This sentiment reflected the twisted continuation of the independence movement in chauvinist format, largely driven by deep resentment towards populations of Indian origin. When the 1930 and 1938 Indo-Burmese riots broke out, Indians had to leave the country (Mazumder, 2014; Warren, 2002). The anti-Indian rhetoric was constructed around the general fear of having Burmese people replaced in all the domains of employment by foreigners. Hence, Burmese farmers who had lost much of their land prevented Indians, who already held economic power in the country, from controlling their properties (Bowser, 2021, pp. 126-127). The widespread discontent targeted foreigners like Indian moneylenders and landowners who demanded expensive interest rates after having acquired land, or Indian workers who enhanced the competition in the labour market (Brown, 2011, p. 730; Siok Hwa, 1965, pp. 115, 134).

Thirdly, the border region of Arakan hitherto poorly controlled began to be strictly regulated (van Schendel, 2005, p. 146). Image 4 illustrates, for example, the maritime border between colonial India and colonial Burma on the river Naf, which was not formally settled for years (van Schendel, 2005, pp. 57, 335). Authorities enforced border controls that became crucial for recognising people’s identities, generally in relation to their home locations (van Schendel, 2005, p. 191). However, this approach proved ineffective, particularly as it overlooked several local patterns: the practice of so-called “borderlanders” who used to cross the border without identification documents, and small-scale border traffic; the distinction between residents and migrants from the same borderland was not always clear; and controls at the border often failed to occur effectively (van Schendel, 2005, p. 191).

As historian Willem van Schendel (2005) has explained, crossing the border was often depicted at a national level as an act of betrayal. Overall, Rohingyas and others residing in border areas used to move across the region. These movements have persisted even after the establishment of the border, leading to two major consequences: the movement of people has been labelled as “international migration”, whether authorised or not, and outmigration began to be regulated (van Schendel, 2005, p. 211).

Exclusionary policies against those perceived as a threat - who are often part of a minority and live in borderlands (Appadurai, 2006; van Schendel, 2005) - were implemented to control resources in Arakan, a region rich in natural resources, as well as economic and

infrastructural projects (De Mersan, 2018, p. 227).⁷⁴ Moreover, illicit trades and shadow markets - which developed in this border region - facilitated the transit of goods such as arms and drugs (van Schendel, 2005, 2006, pp. 7, 8), but not of people. Border controls have not restricted the exchange of illegal goods; instead, securitisation measures and restrictions sought to manage the movement of people. However, borders have also been described as areas of resistance (Khosravi, 2019, p. 24), and in this case many Rohingyas have chosen to cross the international border to flee, as soon as they became target of direct violence, but also contest power dynamics.

Roshida,⁷⁵ one of the eldest research participants living in the informal settlement camp, describes this region as a “border” that has changed. During times she addresses by means of her memories, she recalls that everyone used to cross easily from one side to the other. This “old way” of moving seems similar to the practices I observe among Rohingyas crossing camp divisions.

The idea of the border as a strict division has been introduced in the region as late as 1937 when British India was divided from British Burma. Authorities in Bangladesh have reinforced the concept of the border through refugee camps and their management in 1991-1992 and 2016-2017. The borders of the camps in Bangladesh are nowadays much more prominent than the international border in the lives of the Rohingyas. As many Rohingyas have explained to me, free movement across the international border is no longer practicable, whereas movement across and outside the camps is not given up so easily, even if forbidden.

The institutional representative of a camp in Bangladesh describes the region as a “fluid territory”. This used to be the junction between India, Myanmar, and Bangladesh in the three regions of Tripura, Arakan, and Bengal:

“Due to overpopulation, British rule and the establishment of new nation-states, the situation has become quite problematic. Moreover, Arakan has been independent for a long time and has undergone many changes in religion over the years; all this is reflected in their [Rohingyas’] culture, which has kept the border fluid, allowing people to move easily from one side to the other.”

(Camp-in-charge person,⁷⁶ personal communication, 4 April 2022)

⁷⁴ See footnotes 79, 80 and 81 in the next chapter.

⁷⁵ The names of the research participants have been changed to maintain their anonymity.

⁷⁶ The term “camp-in-charge person” refers to the governmental representative in each camp.

The administrator of the camp disagrees with the term “border” as a politically fixed demarcation. Instead, he prefers to use the word “frontier”, which emphasises characteristics of confrontation and fluidity, as well as cultural and economic exchanges in a region that has been divided by the international border. This “camp-in-charge” person is one of the few with such progressive visions. He identifies the colonial rule and the introduction of nation-states as crucial factors to consider when analysing the condition of Rohingyas who navigate this context of displacement with the same fluidity of previous historical moments.

Since 1937, Burma has progressively implemented migration policies to disrupt the so-called circular migration that has characterised mobilities in the borderlands. The border with India officially divided the region in 1937, and over the subsequent years, various episodes of violence in Arakan have exacerbated this separation. During WWII, military confrontations between pro-Japanese and pro-British forces further aggravated and complicated the burdensome colonial legacies of the region.

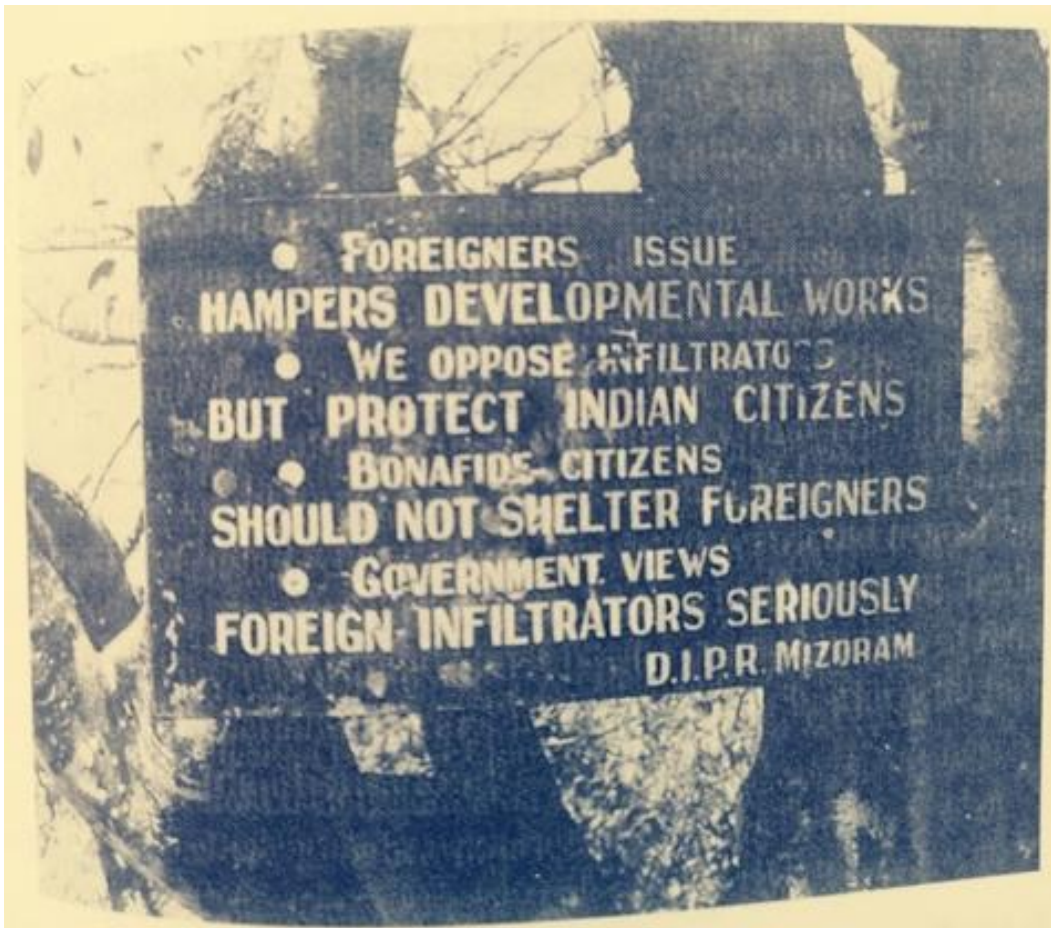


Image 3: A board at the international border with India (van Schendel, 2005, p. 191).



Image 4: The buoy demarcating the border on the river Naf between Bangladesh and Myanmar. (van Schendel, 2005, p. 335).

4. World War II: pro-Japanese Buddhists and pro-British Muslims in Arakan

In January 1942, Japan invaded Burma (Charney, 2009, p. 71). By the end of March, the capital city of Arakan, Akyab was bombed. This led to the retreat of the British Army, the definitive collapse of its colonial administration and, along with the anti-migrant discourse in the country, 400,000 Indians fled from Burma (Leider, 2023, p. 352). These events aggravated local tensions in Arakan, especially when Japan received stronger support by members of the Burmese majority, while the British presence was backed by Muslims. In Arakan, Muslims felt threatened by the discourses against migrants and minorities in the country. The Burmese majority had witnessed the rise of nationalist and anti-imperialist movements and, to an extent, identified with Tokyo's slogan "Asia to the Asians" and its ideology instrumentalising Zen Buddhism.

Throughout all Arakan the situation was tense. In Central Arakan in March 1942, Rakhine Buddhist villagers attacked Muslims, resulting in many being killed or forced to leave (Leider, 2023). One month later, violence erupted in North Arakan, particularly in the towns of Maungdaw and Buthidaung.⁷⁷ There, Muslims were the majority and targeted the Buddhists, who then fled southwards (Leider, 2023, p.351). Violence against Muslims persisted at least until June 1943 in Arakan (Leider, 2023, p. 354). While the British perceived the Rakhine Buddhists as traitors, Muslims and Chittagonians in North Arakan showed loyalty and supported them from 1942 to 1944 (Leider, 2023, p. 360). After the failure of the Allied Forces' First Arakan Campaign (December 1942 – May 1943), the British finally gained control of Northern Arakan in late 1944 and later of Akyab.

While WWII turned towards its closure in 1945, the Allied Forces also regained control of this region. Still, some of the tensions aggravated by the war continued in new ways, especially between the British administration and Buddhist leftist social actors until Burma's independence in 1948 (Leider, 2023, p. 355). Moreover, banditry was a serious problem between 1946 and 1947 in some parts of Arakan as, the British had initially distributed arms to the Rakhine rebels during WWII. In contrast, the northern parts of Arakan remained stable and attracted migration from Chittagong (Leider, 2023, pp. 359, 361).

During WWII, a Muslim autonomist group living in northern Arakan (see image 5 for the map) adopted the name Rohingya. This term began to appear in the names of political organisations formed by educated young Muslims, as well as in cultural and militant groups

⁷⁷ Maungdaw and Buthidaung are towns in north Rakhine State, close to the international border with Bangladesh, as shown in the map of image 5.

in north Rakhine. Either in the attempt to differentiate themselves from other groups or to define their community, Rohingyas emphasised some characteristics for their identity formation in northern Rakhine State in two moments. Some groups of Muslims advocated for an autonomous Muslim region in the towns of Maungdaw, Buthidaung, and Rathedaung (Leider, 2018, p. 9). Later, these processes acquired even more importance after Myanmar's 1948 Citizenship Act established an exclusive criterion whereby only groups permanently present before colonial rule could be recognised as national races and citizens. At this point, identity began to play a crucial role in determining citizenship and rights, especially amid rising anti-Indian and anti-foreign sentiments in the country. Moreover, state authorities exploited tensions between Buddhists and Muslims in Arakan for their agendas. Against this backdrop, the Rohingyas sought an identity distinct from other Muslim ethnic groups in the country, using the term "Rohingya", and legally were granted a citizenship (Leider, 2018, p. 10). Leider (2015) has argued that the Rohingyas hybridised their history, striving both to unite Muslims in Arakan and to contest the prevailing nationalist Buddhist narrative (27). However, as highlighted by Prasse-Freeman and Mausert (2020) rephrasing Leach's (1960) work, various and even exclusive ethnicities could coexist alongside a dominant "super-ordinate ethnicity", such as the Rohingyas (11). This has been observed in Arakan, where alliances are more relevant than differences (de Mersan, 2019, p. 12).

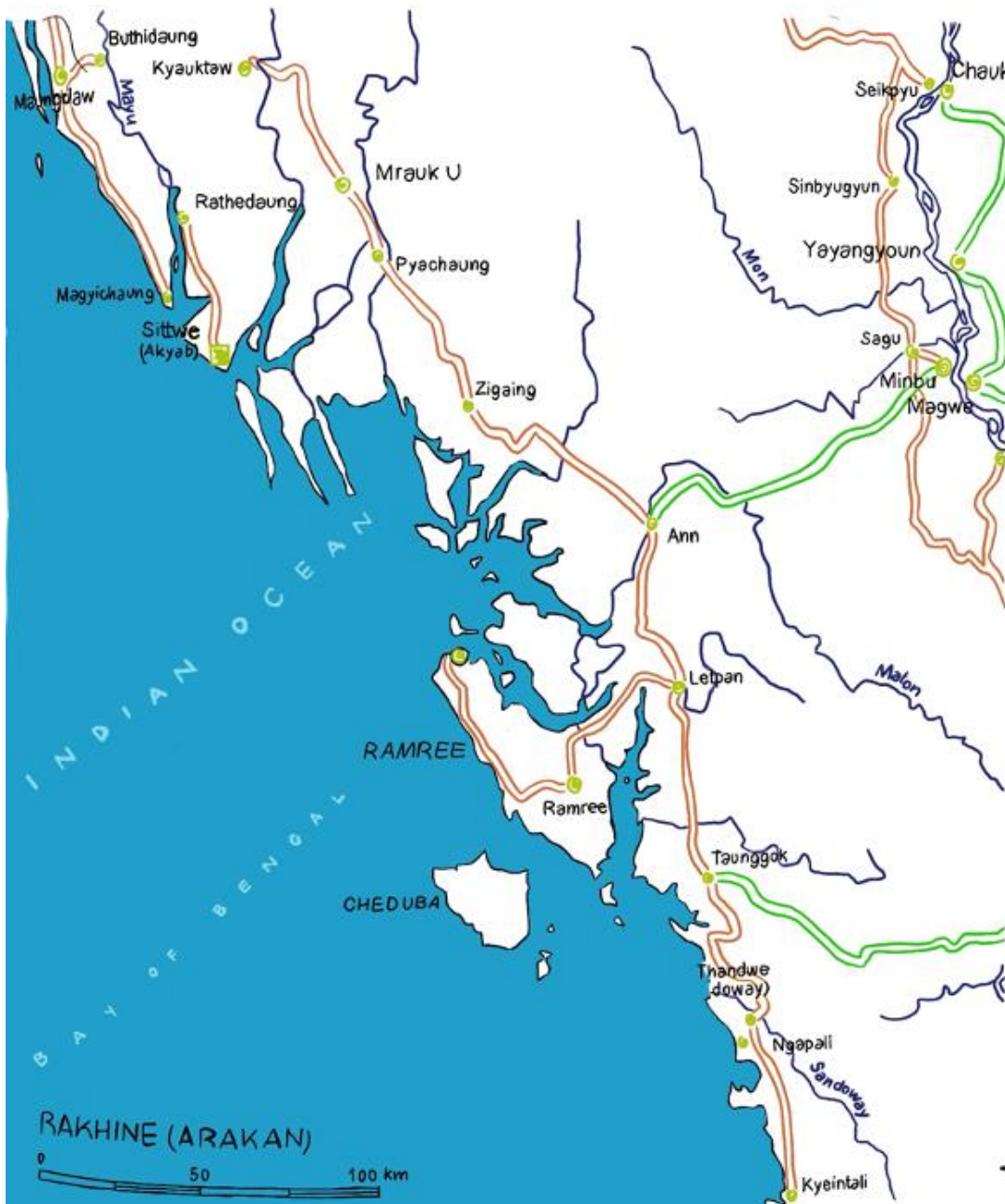


Image 5: Map of Rakhine State, Myanmar. ⁷⁸

5. Concluding Remarks

The precolonial demography of Arakan confirms that circulation in the region has a long history. Prior to the British presence, Muslims and Buddhists lived in the region. After the colonial implementation of the Bengali Immigration Scheme, other Hindu and Muslim people settled to Arakan as well. Muslim Indians intermingled with the “Arakanese Mahomedans”

⁷⁸ I drew the map of image 5, which was originally published elsewhere (Blume B., 2020, *Myanmar*, München: Reise Know-How Verlag) and does not display updated information on the roads and the island “Cheduba”, which is now “Man Aung” island, but still it gives a visual idea of the region and its northern part.

because they could marry Buddhist women who converted to Islam (in this case their children were called *Zerbadi*) and in general were not clearly distinguished from local Muslims in the census activities. In 1937, Burma was separated from the rest of British India. In the post-independence period, both Muslims and Hindus were targets of discrimination. The circulation of people and border controls were managed much more strictly, and migration became associated with the idea of invasion. Despite these new measures, the “borderlanders” kept crossing the border. Hence, the border changed, but Rohingyas and other people kept moving across old and new borders. During my fieldwork, various historical events are described as crucial aspects to understanding the condition of Rohingyas, such as the colonial rule, the overall partition process, nationalist discourses, local tensions and the WWII violence.

To sum up, the Rohingya refugee condition in Bangladesh and Myanmar is the result of the partition process in the South and Southeast Asian domains of the British colonial empire, and of their aftermath.

CHAPTER THREE Literature Review on Rohingya Forced Migration

Straddling South Asia and Southeast Asia, the “Bengal borderland” is one of the most marginal research focuses, even in border studies (van Schendel, 2005, p. 11). Yet, this region between Rakhine State and Chittagong has attracted international attention both due to geopolitical interests^{79 80 81} and the forced migration of Rohingyas in 2012, 2016 and 2017. Within the last decade, over 750,000 people left Rakhine State and took shelter on the other side of the border, in Bangladesh. One of the main challenges to study Rohingya forced migration is the amount of literature to engage with, as related contributions have been published exponentially over the last ten years. I could not engage with all the literature that has been published on Rohingyas. I selected the contributions that are relevant for the understanding of the historical context that forced Rohingyas out of Myanmar, and the ones addressing the legal discussion that excludes them from basic rights in Asia.

The term “forced migration” narrows down the research focus as it shifts the attention to the creation of difference through partition dynamics and processes,⁸² the establishment of nation-states, their violent impact on people’s life and the subsequent displacement of millions of people across the region (Banerjee & Samaddar, 2019, p. 45). For this reason, this chapter refers to historical contributions to examine the nation-building processes in Burma and its complexities that led to the Rohingya forced migration. It will show that the scarce feeling of solidarity in the newly established country, diffused insurrections, most of the time governed by military regimes, the widespread hostility towards minorities and the general economic fragility contributed to the violence, abuses and an overall climate of physical repression in Rakhine State to the extent that Rohingyas fled in large numbers, in 1948, 1959 and 1978. The conflict later (2012, 2016 and 2017) intensified as an ongoing

⁷⁹ Since 2000, South Korean and Indian oil companies have explored gas fields located off the Burmese coast (van Schendel, 2006, p. 14). As part of the “Look East Policy”, India engaged in purchasing gas regionally and in 2008 the Multi-modal Transit Transport Project was launched to connect Kolkata to the Sittwe port (Chaudhury & Samaddar, 2018, p. 7).

⁸⁰ The maritime potential of Rakhine State, with its access in the north of Bangladesh, has attracted Chinese interests too. In 2008, a Chinese state-owned investment company developed the infrastructure in Kyaukphyu (Rakhine State), a Special Economic Zone (SEZ) inclusive of a deep-sea port on Ramree island - part of the China–Myanmar Economic Corridor (CMEC) - transport projects and a pipeline from Kyaukphyu to the Yunnan province (Chaudhury & Samaddar, 2018, p. 7).

⁸¹ The relations between the CMEC’s projects (as well as India’s infrastructures) and the episodes of violence against Rohingyas in 2012, 2016 and 2017 remain discussed as some civil society social actors argue that the CMEC exacerbates violence in northern Shan State and also in Rakhine State (Aung, 2024). The CMEC has worsened ethnic fault lines by supporting the Arakan Army group in Rakhine State for the autonomy of Rakhine Buddhists (Lindsay, 2019).

⁸² Partition studies essentialise partition *stricto sensu* as the moment of India’s fragmentation in 1947. As mentioned in chapter 2, the overall partition pertains to the process that unfolded in the region for decades.

“genocide” aimed at the physical extermination of the Rohingyas, as well as the obliteration of their identity.

This chapter argues that as soon as migration acquires the characteristic of forced displacement, legal debates gain prominence in the academic discussions on Rohingyas, as shown in the work of Western and Asian scholars (anthropologists, historians and political scientists)⁸³. The legal scholar Bhupinder S. Chimni emphasises that each migration should be analysed within its local context, while bearing in mind that the global geopolitics aims to contain migration in the Global South (Chimni, 1998; McConnachie, 2016). Hence, the importance of addressing the legal discourses within the country of shelter.

This chapter will also outline the main contributions and themes analysed concerning Rohingya forced migration. In particular, it will argue that there has been a tendency to approach the study of Rohingya migration by following a specific narrative that does not always account for the diversity of Rohingyas. This chapter aims to emphasise the importance of investigating the persecution of Rohingyas, as well as the absence of rights that characterise their life in Bangladesh and it attempts to answer the question: What has the existing literature on the Rohingyas contributed to?

1. Post-Independence in Burma and Rohingya Forced Migration (1948, 1959, 1978)

After the assassination of General Aung San in 1947, likely due to his rivalries, Burma gained independence (Charney, 2009, pp. 48, 70). In 1947, U Nu was elected as the provisional president and Prime Minister of Burma as a newly established country. He governed in a national context where the Burmese people had not fought any revolution to achieve independence. In addition to this, the presence of weaponry throughout the country facilitated continuous insurrections, which ultimately led to a civil war (Charney, 2009, pp. 72, 73). In northern Arakan, for example, Burmese troops attacked Maungdaw, Bawli Bazaar, and Taungbro, in response to some Muslim Mujahid rebellions in late 1948 (Leider, 2023, p. 361). The general hostility towards minorities was grounded for many Burmese people on their shared experience that capitalism intertwined with colonialism, and the presence of foreign capital that was owned by non-European elites, like Chinese or Indian, was seen as the cause of past exploitation (Charney, 2009, p. 81). Even if Burma was on

⁸³ Among others, Charney, 2009; Chaudhury & Samaddar, 2018; Cheesman, 2017; Crisp, 2018; De Mersan, 2019; Farzana, 2015; Guhathakurta, 2017; Lee, 2021; Leider, 2020; Lewa, 2008; Phiri, 2008; Prasse-Freeman, 2017; Siok Hwa, 2012; N. Uddin, 2020; van Schendel, 2005; Wong & Suan, 2012.

the verge of an economic collapse, the rise of Burmese nationalism escalated during these years and targeted minorities who were sustaining sectors of the country's economy (as explained in the previous chapter with the 1930 and 1938 riots). Anti-migratory sentiments were rooted in the experience of colonial rule. In Arakan, Indian Muslims and Muslims from Arakan were grouped together, and both were targeted in episodes of violence without differentiating the two groups (Chaudhury & Samaddar, 2018, p. 10). A key explanation for this early postcolonial development lies in the intertwining of formal independence and nationalist movements with the colonial legacy, which governed people's lives in an excessively rigid manner. Coupled with the results of WWII violence, this led to a precarious, fragile and vulnerable situation for people at the border.

Following Burma's post-World War II independence from Britain in 1948,⁸⁴ the status of minorities gradually deteriorated, especially in border regions. In this context, Indians and Pakistanis without citizenship were required to apply for temporary residence permits, as the result of a restriction already implemented in 1941 by the Indo-Burman Immigration Agreement (Siok Hwa, 2012, p. 136). In other words, the new Burmese state began to control foreign residents and did so also through the regulation of their remittances (Amrith, 2015, p. 229). Besides, non-Burmese citizens were not allowed to leave the country for more than 60 days; otherwise, their visas would be revoked.⁸⁵ To the same extent, additional control posts along the border with East Pakistan (present-day Bangladesh) were established (Leider, 2023, p. 361). Authorities intervened at the border after forbidden migration and rebellions occurred, resulting in violent clashes with the "borderlanders". Van Schendel has described this and other similar scenarios as the "border effect" emerging after the creation of new nation-states (van Schendel, 2005, pp. 33). Like other border areas, Arakan represented the national territory's extreme frontiers, where the state aimed to impose its presence to separate citizens from "the other" (van Schendel, 2005, p. 334). This practice led to "partition-induced migration" of so-called foreigners who had to leave the newly established country for another where their religion was dominant (Banerjee & Samaddar, 2019, p. 53). Due to Buddhist and Muslim separatist movements in the region, Burmese troops intervened in the region in 1948 and 1949, in an atmosphere of violence, crime, and poverty: 5,000 people were displaced into East Pakistan, present-day Bangladesh (Leider, 2023, p. 362). Some sought refuge with relatives, who were living on

⁸⁴ Burma gained independence earlier, which had been suspended and re-negotiated between 1945 and 1947 (Charney, 2009, p. 71).

⁸⁵ Visas were introduced in 1952 (van Schendel, 2005, p. 235).

the other side, while others ended up in camps until their return to Burma in July 1949 (Leider, 2020, p. 3).

In 1956, U Nu renounced his position as Prime Minister and was replaced by Ba Swe for one year (Charney, 2009, p. 86). Again in 1958, he asked that the military and the Commander of the Armed Forces, General Ne Win, take over until 1960 (Charney, 2009, p. 92). During this post-independence period, widespread upheaval in Arakan led the Burmese government to militarise the region (van Schendel, 2005, p. 276, 281). Between March and August 1959, Muslims were forced to flee in large numbers to East Pakistan: Burmese media reported 13,500 displaced persons, and Pakistani media counted 17,600 refugees (Leider, 2020, p. 3). In September 1959, Burma's General Ne Win agreed in Karachi (West Pakistan) that the Burmese authorities would accept the return of residents but would refuse "irregular migrants". This manoeuvre was part of a broader strategy to classify a large part of displaced people as foreigners (Leider, 2020, p. 3). Meanwhile, northern Arakan Muslim leaders suggested that they join Pakistan, although Muhammad Ali Jinnah, Pakistan's first governor at the time, had already rejected this request in 1946 (Leider, 2018, p. 7; van Schendel, 2005, p. 115). The Muslims of north Arakan have long sought British and Pakistani support to establish an autonomous and exclusive zone.

In 1960, after U Nu had won the elections, the military surrendered, but kept control over the national territory (Charney, 2009, p. 93). Concurrently, in response to the Mujahid insurrections (from 1949 to 1961), Prime Minister U Nu established the Mayu Frontier Administration in Arakan (Leider, 2023, p. 360). In May 1961, northern Arakan (i.e., Maungdaw, Buthidaung, and Rathedaung) was declared a distinct administrative entity under the Mayu Frontier Administration, with the deputy chief of defence Brigadier General Aung Gyi at its head. This was an official declaration, recognising the Rohingyas as an ethnic group, and special forces started to manage the region (Leider, 2018, p. 10). In this phase of nation-building process, Buddhism was declared the national religion (Charney, 2009, p. 94). In 1962, General Ne Win seized power under "the Burmese way to Socialism" (Charney, 2009, p. 103), and the military administration governed the region of Arakan for two more years (De Mersan, 2018, p. 221). Despite the presence of Rohingya armed groups in north Arakan from 1965 to 2005, government and military control over the region was accomplished almost effortlessly due to the local rivalries between the Arakanese Buddhists and Muslims (Leider, 2018, p. 15).

During Pakistan's war with India and the ensuing civil war from 1970 to 1971 that led to the creation of Bangladesh as a new independent country, ten thousand refugees from East Pakistan sought refuge in Arakan (Leider, 2018, p. 15). Therefore, that peak of a long and violent struggle for independence in Bangladesh compelled many to cross the border into Burma and take shelter in Arakan. Following the subsequent 1974 establishment of the State of Arakan as an autonomous region of Myanmar, the military were in the position to intervene. A particularly aggressive operation took place in 1978: Operation *Naga Min* claimed to verify people's identities and irregular migrants, especially after many people from Chittagong had taken shelter in the region in 1971. This violent operation led to the mass exodus of 250,000 refugees who sought shelter in the young independent state of Bangladesh (Cheesman, 2017, p. 472).⁸⁶ Between August and December 1978, based on a bilateral agreement between representatives of the Dhaka and Rangoon governments, Burma accepted the repatriation of 200,000 people from Bangladesh (Cheesman, 2017; Leider, 2020, p. 3; Uddin, 2020). Some Rohingyas, who were not returned, stayed in Bangladesh, and others migrated to Pakistan and Saudi Arabia (Leider, 2018, p. 15).

For a short while, the borderland situation and the conditions for Rohingyas became somewhat easier, also because the Burma Socialist Programme Party (BSPP) - in power between 1962 and 1988 - conveyed a successful image of its political achievements to the international community (Charney, 2009, p. 143). Between the 1980s and 1990s, Rohingyas established a stable network of solidarity within their diaspora based on Muslim identity, and sustained their cause worldwide (van Schendel, 2005, p. 295).

2. The 1982 Citizenship Law and the Rohingya Forced Migration of 1991 and 1992

A number of military operations continued at the western border in Arakan and in 1982 the new Citizenship Law was approved. Under that law, Rohingyas were denied nationality on the grounds that they were not considered to represent one of the "national races" (van Schendel, 2005, p. 392) and were revoked their citizenship.⁸⁷ The 1982 Citizenship Law

⁸⁶ Chaudhury and Samaddar (2018), as well as De Mersan (2018) and Lee (2021) refer to 200,000 Rohingyas fleeing in 1978, and Wong and Suan (2012) refer to 187,250 Rohingyas being repatriated from Bangladesh in 1979 (80). I think that 250,000 is the correct figure that corroborates Myanmar's position of refusing, during each return programme, to accept some people. Furthermore, Chaudhury and Samaddar argue that immigration authorities confiscated registration cards from Rohingyas in 1978 (Chaudhury & Samaddar, 2018, p. 11), and not in the late 1980s, as explained by Cheesman (2017). Cheesman's explanation appears more plausible as Rohingyas have their cards confiscated probably when the 1982 Citizenship Law was implemented, as explained in the next section.

⁸⁷ In the 1950s, concrete proof of nationality was required through national registration cards (referred to as NRC), which, since the 1970s, were no longer issued to Rohingyas and were later confiscated from them (Leider, 2018, p. 14).

introduced three types of citizenship: citizen, associate citizen, and naturalised citizen, corresponding to colour-coded cards. The law declared that ethnic groups who had resided in the country since 1823, namely before the first Anglo-Burmese War that led to the British presence in the territory and the colonial period, were considered Burmese citizens (Pyithu Hluttaw Law, 1982, section 3). Furthermore, section five of the law defined each national as a citizen by birth if they were born to parents who were both nationals (Pyithu Hluttaw Law, 1982) or who held a certificate of citizenship.

As the political scientist Nick Cheesman accurately explains, the 1982 law referred to the “certificate of citizenship” previously granted to many Rohingyas under the *Union Citizenship Act* of 1948. Therefore, once the law was enacted under the military body in power (the so-called State Law and Order Restoration Council, i.e., SLORC) which had seized power under the rule of Saw Maung in 1988, these criteria should not have posed any difficulties for the Muslims in Arakan (Cheesman, 2017, p. 472). Nevertheless, officers refused to register many individuals to whom “white cards” were issued, which were temporary registration cards used as alternative identification documents. For this reason, Cheesman addresses the stripping of citizenship that the Rohingyas experienced as *de facto* rather than *de jure* statelessness (Cheesman, 2017, p. 473). Rohingyas had to return their documents and receive the Citizenship Scrutiny Cards (CSC), which were differentiated by colour and ranked Rohingyas with white cards as non-full citizens (Leider, 2018, p. 14).

In 1988, the SLORC military junta had defined the “135 national races of Myanmar” as part of the “Myanmarisation” nationalism. In many ways, this was recalling, re-defining and reinvigorating those groups already mentioned in previous British censuses (Gravers, 2007, p. 4). The contradiction of the Myanmarisation nationalism clearly emerged as in the post-independence phase it was common belief that the country’s problem was rooted in the colonial rule, as also publicly expressed in 1982 by General Ne Win (Charney, 2009, p. 142). However, nationalist policies began to directly use categories from the colonial censuses. During the British Raj, the colonial administration had classified individuals based on religion, eight major ethnic categories and 135 languages (Gravers, 2007, p. 4). This had not taken into account many aspects of the pre-colonial contexts of Burma, where people were often organised into socio-professional lineages (De Mersan, 2018, p. 217). The rise of nationalism closely tied to the process of nation-building has clear elements of chauvinist exclusion, and the subsequent representation of certain minorities, such as the Rohingyas, as irregular migrants or traitors within a national context. The ensuing divide between the

Burmese majority and many minorities living in border regions foreshadowed recent nationalist discourses and episodes of violence against these groups (Siok Hwa, 2012, pp. 232, 234).

In the 1990s, the SLORC reintroduced the army in the border region of Rakhine State.⁸⁸ Lands were confiscated, and people were relocated under the orders of the *Nasaka*, the police and intelligence unit, which harassed the Muslim population and restricted freedom of movement (Charney, 2009, p. 185). Burmese Buddhists resettled in northern Arakan, displacing the Rohingyas from their homes, whose identity documents were taken away and resisters were raped (Charney, 2009, p. 185). Marriage and birth registrations were restricted, and certain Muslim religious practices became forbidden (Leider, 2018, p. 16). A massive exodus of 250,000 Rohingyas took place between 1991 and 1992 (Leider, 2018, p. 16), and 90% came from Maungdaw and Buthidaung (Leider, 2020, p. 4). In these circumstances of violence, inflicted by the local border police, 250,000⁸⁹ Muslims settled in refugee camps in Bangladesh when, in mid-February 1992, the government requested the UNHCR to assist with their management (Chaudhury & Samaddar, 2018, p. 11).

In 1992, fourteen refugee camps were established in Bangladesh (personal communication with Mr Douza at the Refugee Relief and Repatriation Commissioner, 22 May 2022), following the initiative of Médecins Sans Frontières France and the diplomatic intervention of President Mitterrand and his wife (for more details, see footnote 133). Repatriation programmes of Rohingyas to Myanmar were launched soon afterwards and managed by the government of Bangladesh. In November 1993, Myanmar signed a Memorandum of Understanding with the UNHCR, which also took part in repatriation programmes and arranged the return of 230,000 individuals to Myanmar (Wahra, 1994). The return of Rohingyas often happened under duress (Crisp, 2018) as many did not want to go back. While some escaped the forced returns pursued in Bangladesh and left for Pakistan or other Arab countries, those who were repatriated continued to face violence and persecution, and later smaller groups of Rohingyas crossed back over the River Naf to return to Bangladesh. Based on the Bangladesh - Myanmar Agreement between 1992 and 1999, 230,596

⁸⁸ In the attempt of re-establishing law and order, the military regime changed the names of the country, its locations and citizens. The Law on the Substitution of Terms was enacted in October 1988 and adopted the name “Union of Burma” for the country that was soon after changed into Myanmar (Charney, 2009, pp. 171, 172).

⁸⁹ Uddin refers to 200,000 Rohingyas fleeing in 1991-1992, but this might be a mistake, as he also mentions that 236,000 were afterwards repatriated (Uddin, 2020, p. 174). A disaster officer working for Oxfam writes in 1994 that 300,000 Rohingya refugees took shelter in Bangladesh (Wahra, 1994, p. 45).

refugees were returned (UNHCR Global Report, 1999, p. 229) after being coerced through various means (Crisp, 2018, 2022). As Guhathakurta reported, 20,000 Rohingyas were registered in the 1990s and stayed in the country in two camps, Kutupalong and Nayapara camps, where by 2011 the number had grown to 29,368 (Guhathakurta, 2017, p. 651). Gradually, besides, repatriated Rohingyas who migrated back to Bangladesh settled in makeshift settlements next to the Kutupalong camp (20,000 people), and the Nayapara camp (13,500 people).⁹⁰ ⁹¹ Furthermore, between 300,000 and 500,000 undocumented nationals from Myanmar returned to Bangladesh and moved to the Cox's Bazar area (Guhathakurta, 2017, p. 651; Sengupta, 2018) whose presence could never be precisely verified (Farzana, 2015, p. 293).⁹²

Only two camps have remained open since the 1990s. Rohingyas living in the two old camps are “registered” and therefore authorities are aware of the capacity of the camps. There has been some initiative to count Rohingyas in the makeshift settlements as well - for a total of around 30,000 people – but the number of Rohingyas living outside the camp area oscillates between 300 and 500,000 people (Chaudhury & Samaddar, 2018, p. 29; Guhathakurta, 2017, p. 651). These figures are merely an estimate. Each Rohingya forced migration to Bangladesh has been followed by return programmes (Leider, 2020), but Myanmar has always repatriated fewer people than those who had fled. Therefore, without accounting for the unmonitored entries of smaller groups of Rohingyas into Bangladesh, there might already be between 100 to 200,000 individuals who remained in the country after their migration.

3. Rohingya Forced Migration in South and Southeast Asia

Rohingyas are frequently associated with Bangladesh because most of them fled Myanmar and sought refuge in this neighbouring country, at least in the first stage of their migration.⁹³ Throughout my fieldwork, Rohingyas describe Bangladesh as a residence country.⁹⁴ The perspectives of Rohingyas that this research considers include those of new mothers and

⁹⁰ Kutupalong and Nayapara are called “registered camps”, as explained in chapter 4.

⁹¹ Religious International NGOs like Islamic Relief and Muslim Aid constructed the Leda makeshift settlement, next to Nayapara camp, for around 10,000 unregistered people (Lewis, 2019, p. 1891).

⁹² Some scholars, while acknowledging the difficulty of enumerating unregistered individuals, stated that 850,000 Rohingyas are unregistered in Bangladesh (Chaudhury & Samaddar, 2018, p. 4).

⁹³ See, for instance, *Rohingya Emergency*, UNHCR (available at: <https://www.unhcr.org/emergencies/rohingya-emergency> , last accessed on 12th February 2025).

⁹⁴ Some of my research participants still mention Malaysia as a possible destination. From there, they might be resettled to third countries like the United States, although only a few places are available annually (O'Brien & Hoffstaedter, 2020). Furthermore, since 2025 Trump's administration, the situation for refugees in the United States is uncertain.

birth attendants who do not aspire to leave Bangladesh and cross the sea to reach another place. Nonetheless, considering the precarious living conditions many refugees face, Bangladesh is also described as a transit country in several contributions.⁹⁵ The sea interconnects people in Asia, and mainly young men belonging to the second or third generation of Rohingyas in Bangladesh cross the sea to seek employment opportunities elsewhere, risking trafficking or drowning (Sengupta, 2018, pp. 21, 23).

Given the precarious living conditions for many unregistered Rohingyas in Bangladesh, initially, migrating to the Gulf States or crossing the sea to reach Indonesia, Malaysia or Thailand was viewed as an “exit strategy” (Guhathakurta, 2017, pp. 657, 658). Wong and Suan have described the hypermobility of Rohingyas into the Islamic world as a resource that, in 1974, increased to the Gulf states, especially after the oil boom (Wong & Suan, 2012, pp. 78, 81). Specifically, Muslim migration to Pakistan was also facilitated under General Zia Ul Haq’s rule, during which until the 1990s Rohingyas received Pakistani citizenship. While some Rohingyas left Pakistan in the mid-1980s for the Gulf States (where there were approximately 2 million Pakistanis), others went directly to Saudi Arabia with an *Umrah* visa⁹⁶ (Wong & Suan, 2012, p. 83). Saudi authorities recognised the Rohingyas as *prima facie* refugees, and in 1994, even a foreign passport – usually irregularly issued in Bangladesh - granted them temporary permits to stay.

In Malaysia, the first Rohingyas settled in 1978 and the rest arrived in 1992 in the capital city (Wong & Suan, 2012, p. 85).⁹⁷ Since moving to the Gulf States became challenging, between 2006 and 2008, over 8,000 Rohingyas departed from Bangladesh to Indonesia, Malaysia, or Thailand by boat, and scholars have compared them to the Vietnamese refugees who in the mid-1970s fled Vietnam by boat (Lewa, 2008). Even journalists started referring to Rohingyas as “Asia’s new boat people”.⁹⁸ In the 1990s, those Rohingyas who had reached Malaysia obtained work permits for six months (O’Brien & Hoffstaedter, 2020, p. 7). From 2002 to the end of 2005, the UNHCR issued them temporary protection papers, and the government issued residence and work permits as well, which were suspended in the summer of 2006 (Wong & Suan, 2012, p. 87). The position of the

⁹⁵ Chaudhury & Samaddar, 2018; Guhathakurta, 2017; Lewa, 2008; O’Brien & Hoffstaedter, 2020; Uddin, 2020; Wong & Suan, 2012.

⁹⁶ The Saudi Arabian authorities issue a *hajj* visa two months before the pilgrimage that Muslims make to the Mecca during a specific timeframe in the year; the *umrah* visa is available throughout the year to make an additional pilgrimage to the Mecca (Visa Saudi Arabia, 2020).

⁹⁷ The second generation of Rohingyas, who were born and grew up in Malaysia, do not usually identify as “Rohingya” (Lukmanulhakim, 2025).

⁹⁸ See, for instance: <https://www.bbc.com/news/world-asia-32778942>.

UNHCR in the country has remained unclear with regard to the application of the right of asylum (Perrodin, 2024, pp. 12, 13).⁹⁹

Crossing international borders has gradually toughened also due to some developments in Bangladesh. The Awami League government has been in power from 2009 to 2024, and halted several Rohingya inflows (Sengupta, 2018, p. 22). Generally, the party appeared more intolerant towards Rohingyas than the opposition party, the BNP or Bangladesh Nationalist Party (Guhathakurta, 2017, p. 653). However, it soon became evident that both parties nurtured the anti-Rohingya narrative that was growing amidst economic difficulties for the local population of southeast Bangladesh, accusing Rohingyas of being involved in *ya baa*¹⁰⁰ smuggling (Guhathakurta, 2017, p. 649). The investments made in infrastructure for Rohingyas in Bangladesh were labelled as pull factors and, along with resettlement programmes, were ostracised in the country (Guhathakurta, 2017, p. 654). For a long time, Bangladesh refused to build adequate infrastructure for Rohingyas and implemented a closed borders policy that was abandoned in 2012 after having pushed back several Rohingyas (Sengupta, 2018, p. 33). Afterwards, the government adopted an intolerant approach towards Rohingyas, as demonstrated by the “Thengar Char” policy, which aims to resettle Rohingyas on an uninhabited island (now best known as ভাসানচর, Bhasan Char) so that Cox’s Bazar would be less affected by the presence of refugees (Guhathakurta, 2017, p. 654; Sengupta, 2018, p. 30). Despite negotiating bilateral repatriation agreements with Myanmar, the government of Bangladesh encountered the recent reservations of some NGOs about the premature return of Rohingyas (Crisp, 2018), although other international social actors supported this initiative.¹⁰¹

Given the overall lack of basic rights for Rohingyas in Bangladesh, new routes to southern Thailand and Malaysia have emerged (Lewa, 2008, p. 40), increasing the risk of being trafficked. Individuals arrested in Malaysia have been deported to Thailand, where they were either detained or sent to Myanmar. In both cases, to be released, their families had to pay a fee, and those unable to pay the money ended up in bonded labour on fishing boats or plantations (Lewa, 2008, p. 41). By 2012, there were already between 11,000 and 30,000 Rohingyas in Malaysia (Wong & Suan, 2012, pp. 84, 85). Even though numbers oscillated, some scholars referred to 50,000 Rohingyas who migrated to Malaysia from

⁹⁹ On the implementation of the right of asylum in Malaysia, see the PhD thesis of Louise Perrodin, 2024.

¹⁰⁰ *Ya baa* is a common drug in this region containing methamphetamine and caffeine.

¹⁰¹ This response of premature returns to the country of origin is not an isolated scenario for the Rohingyas: Afghan refugees in Pakistan have been repatriated after episodes of harassment, as have Somali refugees in Kenya, Nigerian refugees in Cameroon, and Syrian refugees in Lebanon (Crisp, 2018).

Bangladesh (Farzana, 2015, p. 293). Between 2013 and 2014, 10,000 individuals were held in detention centres in Malaysia or Thailand (Sengupta, 2018, p. 37). Due to their mobility, the boat people have been often depicted as “economic migrants” since they crossed the sea in search of employment (Chaudhury & Samaddar, 2018, p. 2). However, seeking a job did not erase their experience of forced displacement because Rohingyas have been fleeing due to discrimination and human rights violations. For this reason, they should be recognised as *prima facie* refugees. Instead, they have often been detained and denied basic rights (Lewa, 2008, p. 41).

4. Rohingya Forced Migration in 2012, 2016 and 2017

In Myanmar, Rohingyas are not permitted to move freely, their access to education and healthcare remains limited, and reproductive rights have also been restricted. Since 1994, Rohingya children have been denied local Myanmar birth certificates, and the 2015 Population Control Healthcare Bill has limited the number of children per Rohingya family by introducing birth spacing in some areas of the country (Hutchinson, 2018, p. 4; O'Brien & Hoffstaedter, 2020). Physical acts of violence and discrimination against Muslim communities in Rakhine State occurred again in 2012, 2016, and 2017.

The role of nationalist Buddhist monks has been central in promoting laws aligned with an anti-Muslim agenda, fostering sentiments of violence and discrimination that have spread throughout Myanmar over the last decade (Walton, 2016). For instance, the *Protection of Race and Religion Laws* has promoted such agendas. It consists of four pieces of legislation, like the *Population Control Healthcare Bill* or *Pyidaungsu Hluttaw Law* (2015). An English draft of the Bill is available online (Pyidaunsu Hluttaw Law, 2015), as well as the comments from some NGOs (Equal Rights Trust, 2015). On the basis of this bill, the government has been able to control population growth in specific areas (Physicians for Human Rights, 2015), like in Rakhine State. Article 4 leaves a broad space for intervention to authorities who can decide in which region they regulate population control (Pyidaunsu Hluttaw Law, 2015). The bill “has been widely condemned both for violating women’s rights and for its potential to be used as a tool for ethnic and religious discrimination against communities like the Rohingya” (Equal Rights Trust, 2015).

In this context, in June 2012, riots and tensions between Rakhine Buddhists and Rohingyas in Rakhine State forced 120,000 Rohingyas to flee to Bangladesh, which finally opened its borders (Uddin, 2020, p. 174). In October 2016, the attacks by the Arakan Rohingya Salvation Army (ARSO) - an extremist group of Saudi-trained Rohingyas -

prompted the Burmese military to intervene and destroy Rohingya homes (Prasse-Freeman, 2017, p. 1). Amid this violence, 87,000 Rohingyas left, and in 2017, following the atrocities of the military's outburst, 750,000 Rohingyas fled (Uddin, 2020, p. 174). In 2016 and 2017, violence escalated to the point where the military set houses ablaze, Rohingyas were killed in masses, and the survivors were segregated in camps.¹⁰² At this juncture, the international community and political scientists began classifying these episodes as a "genocide". In five years, a million people crossed the international border and took shelter in Bangladesh where the number of unregistered Rohingyas has increased, especially after the recent outbreak of violence. However, the government of Bangladesh did not immediately acknowledge all Rohingyas and the majority remained unregistered.

From the beginning of the recent influx in 2016 and 2017, the "new Rohingyas" were exposed to precarious living conditions in Bangladesh. Additionally, their arrival raised tensions among the "registered refugees" who have been living in the only two camps for thirty years, as well as with the local population of Bangladeshi citizens. These tensions encompassed numerous issues, such as competition in the labour market, an increase in mixed marriages between Rohingyas and local residents, environmental degradation caused by deforestation for the construction of camps, and the rise of militant activities and ties with right-wing Islamic parties like *Jamaat e Islam* (Guhathakurta, 2017, p. 649; Uddin, 2020, p. 73). The complaints of the "registered refugees" gradually diminished as their living conditions improved after 2017. The local population was concerned with the impact of the humanitarian aid on a national scale, which soon developed into a large-scale humanitarian response to manage the thirty-four camps and extended its services to local people (Lewis, 2019, p. 1885).¹⁰³ In addition to the 32,000 Rohingyas living in the two registered camps in 2017, the group of "unregistered refugees" was finally registered as "forcibly displaced Myanmar nationals" (Uddin, 2020, p. 63).

5. Ethnographic Research Related to Rohingyas, Research on Genocide and International Protection

Most contributions on Rohingyas have focused on persecution, migration to other countries, and how Rohingyas cope with forced migration and living conditions. This section sums up

¹⁰² See the work of the journalist Francis Wade (2017) on Rohingyas' recent persecution in Myanmar, as well as the account of Rohingyas like Mayyu Ali (M. Ali & Lopes, 2022).

¹⁰³ In April 2025, 963,434 Rohingyas lived in the camps in southeast Chittagong, where local population amounted to 541,021 (available at: <https://rohingyaresponse.org/resources-data/>, lastly accessed on 15th of April 2025).

(1.) the work of some scholars who have explored how Rohingyas navigate their living conditions in Bangladesh, it then refers to (2.) ethnographies conducted in Myanmar and Rakhine State highlighting the role of alliances, (3.) studies that concentrate on the notion of genocide, and (4.) instruments of international protection to examine Rohingya forced migration.

Despite of being registered as “forcibly displaced Myanmar nationals”, Rohingyas in Bangladesh have no right to complain to any authority, and the lack of citizenship makes them “absent in the state structure” to the point that they are addressed by the Bangladeshi anthropologist Nasir Uddin as অমানুষ, *omanush*, subhuman (Munira, 2012, p. 50; N. Uddin, 2020, pp. 124, 128, 129). This and similar expressions - i.e., “lesser humans” (Farzana, 2015, p. 305) – are used to refer to Rohingyas’ condition as a group of people in “a much worse situation than human beings normally do” (Uddin, 2020, p. 21). The scholar Kazi Fahmida Farzana has conducted her research before the most recent influx of 2017, and she mentions that women in the congested camps suffer due to a lack of privacy. For this reason, some are married off to local villagers as a sort of strategy to escape this condition (Farzana, 2015, p. 307). She addresses other life strategies as a form of resistance, as the political scientist James Scott has theorised (Farzana, 2015, p. 302). Farhana Rahman (2021) also argues that Rohingya women can activate coping strategies and nurture their sense of belonging. She focuses on the space for prayers and its importance for a group of women in the camps. However, Rahman still points to the limited mobility of women in the camps who are unable to leave their homes due to their husbands’ conservative views (Rahman, 2021, p. 885). In different ways, both Farzana and Rahman investigate the injustices in the camps and, at the same time, how refugees deal with their displacement. Nevertheless, the authors do not approach the differences among Rohingyas in much ethnographic detail. Farzana does not expand on Rohingyas’ diversity probably because she has conducted her research in Bangladesh before 2017, when there were fewer official settlements or camps for her to compare. Rahman argues that Rohingya women are restricted in their mobility in the camps, but her analysis could go further and concentrate on the differences within the group of women. On this subject, my observations in the camps highlight at least three relevant points: some Rohingya families allow women to leave their homes, but this depends on the individual’s age and stage in life; some camps are more dangerous than others, affecting both women’s and men’s mobility; finally, Rohingyas are diverse, and it is likely to observe various habits within the camp area.

The present work builds upon these analyses, as well as the contributions mentioned to examine Rohingyas' constraints, observe their strategies, and engage with their diverse experiences of forced migration, as mentioned in the Introduction of this doctoral thesis. Besides, anthropological works that have underlined the importance of alliances for Rohingyas and other people in this region are crucial for this thesis (De Mersan, 2019; Prasse-Freeman & Mausert, 2020).¹⁰⁴ As pointed out in Leach's monograph *Political Systems of Highland Burma*, the "charismatic and structurally unstable" Burmese kingdoms, networks, and alliances were fundamental for the royals to exert their authority (Leach, 1960 as cited in Prasse-Freeman & Mausert, 2020, pp. 10, 11). Lieberman (1978) highlights the need to focus on the role of alliances and patron-client relationships to grasp the dynamics of the region (as cited in De Mersan, 2019, pp. 11, 12). Finally, Bernot (1967) also emphasises the significance of people's relation to the environment and the distance from the centre of power in the region (Bernot, 1967 as cited in De Mersan, 2019, p. 13). De Mersan (2019) has paraphrased these contributions and shed light on the fact that, in pre-colonial times, differences were not as important as alliances or kinship (12). These anthropological contributions remain a solid reference for this analysis because they showcase that differences may persist, but alliances in the region continue to play a prominent role.

Scholars have addressed recurrent topics in their research with Rohingyas, and they have been influenced by the work of international social actors, but have also gone beyond notions of international law.

The international report by the Human Rights Council has confirmed that the persecution of Rohingyas, including sexual and gender-based violence amounts to the definition of genocide (Human Rights Council, 2019). Both the Rohingya ethnicity and the Islamic religion are factors determining their discrimination in Myanmar, which has also been described as a "slow-burning genocide" (Zarni & Cowley, 2014). This process began with the expulsion of the Rohingyas in 1948, 1959 and 1978, continued with the legalisation of their erasure as a group in 1991 and 1992, and has led to violence, killings, and hate campaigns that have erupted since 2012 under the civilian-military rule of Thein Sein. However, the UN initially avoided using the term "genocide", considering the legal obligations that arise from the 1948 *Convention on the Prevention of the Crime of Genocide*

¹⁰⁴ Rohingya autoethnography is an important genre to understand the differences among Rohingyas (Ahmed, 2023; M. Ali & Lopes, 2022; Prasse-Freeman, 2024).

(*Convention on the Prevention and Punishment of the Crime of Genocide*, 1948). The Convention requires the international community to act through the Security Council in case a state fails to protect its population (Southwick, 2018, p. 126). In this regard, the contribution of Melanie O'Brien and Gerhard Hoffstaedter (2020) is particularly relevant, as they relate the abstract notion of genocide to the reality on the ground for Rohingyas in Malaysia. They argue that Rohingyas' assimilation in Malaysia derives from their cultural loss and is part of the genocide process (O'Brien & Hoffstaedter, 2020, p. 8).

Moreover, past experiences of forced displacement in Asia are relevant to analyse the various discourses excluding Rohingyas in Bangladesh. During the Vietnam and "Indochina" refugee crisis between 1975 and 1978, some countries feared that refugees could have reinforced the "communist threat" (Nguyen, 2016). Similarly, this concern arose during the migration of Rohingyas, often represented as an invasion or a "terrorist threat" (Moretti, 2021, p. 221; van Schendel, 2005, pp. 207, 208). Such narratives were supported in Myanmar and by international media reports that legitimised military operations like the so-called Operation *Naga Min*¹⁰⁵ as a response to alleged Rohingya attacks (Tinmaing & Kanji, 2020, p. 5).¹⁰⁶

While the 1989 *Comprehensive Plan of Action* (also known as CPA) for "Indochinese" refugees provided an international response for managing the mass movements of refugees in the region (Fullerton, 2011), this did not happen for Rohingyas. The Gambia initiated recent proceedings in the International Court of Justice against Myanmar for its violations of the *Convention on the Prevention and Punishment of the Crime of Genocide*¹⁰⁷ (International Court of Justice, 2025). Although the *Application of the Convention on the*

¹⁰⁵ In 1978 the operation *Naga Min* was launched in Arakan by Ne Win's government in order to verify people's identity.

¹⁰⁶ This image of the refugee terrorist is also reinforced by the Bollywood movie *Rohingya – People from nowhere* (H. Khan, 2021). The film represents Rohingyas in camps by combining the image of the victim with that of the terrorist. In this way, the dichotomy of the refugee as both victim and terrorist obscures not only the fact that military operations occurred before the asserted attacks by Rohingyas but also questions the possibility of refugees to oppose resistance against military attacks (Tinmaing & Kanji, 2020, p. 7).

¹⁰⁷ As the legal definition of genocide pertains, this has to be found in the 1948 *Convention on the Punishment and Prevention of the Crime of Genocide*, article 2, as "any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such: (a) Killing members of the group; (b) Causing serious bodily or mental harm to members of the group; (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; (d) Imposing measures intended to prevent births within the group; (e) Forcibly transferring children of the group to another group." (*Convention on the Prevention and Punishment of the Crime of Genocide*, 1948). While numerous scholars have agreed that the term genocide is applicable to the condition of Rohingyas (Lee, 2021; O'Brien & Hoffstaedter, 2020; Siddiquee Basu, 2020; Zarni & Cowley, 2014), the discussion has expanded to whether the definition of ethnocide is more appropriate (N. Uddin, 2022). *The Encyclopedia of Social and Cultural Anthropology* defines ethnocide as the "systematic destruction of the culture (or the members themselves) of a particular ethnic group", whereas genocide as "systematic killing of people because of the ethnic or racial group to which they belong." (Barnard & Spencer, 2011, pp. 903, 907).

Prevention and Punishment of the Crime of Genocide, Gambia v. Myanmar, Provisional measures was a landmark event for the Rohingyas, it cannot be compared to the multilateral cooperation that was termed the *Comprehensive Plan of Action* for the “Boat People” from Vietnam. There has not been any other concrete attempt from the international community to deal with Rohingya forced migration. Therefore, the question of whether the Rohingyas’ protracted refugee situation can be solved with a plan analogous to the 1989 *Comprehensive Plan of Action* must be put aside. While Western countries accepted the Vietnamese boat people under the transnational regime of resettlement programmes, Rohingyas have been left abandoned in camps (Wong & Suan, 2012, pp. 77, 78).

In the domain of international protection Rohingyas are also excluded on various levels, and the following paragraphs highlight related points. The UNHCR recognises Rohingyas as refugees. By contrast, many Rohingyas have lived unrecognised in poverty outside the camp area for years in Bangladesh due to their legal unrecognition. By global standards for statelessness in the early 21st century, the Rohingya situation in Myanmar ranks among the most significant. Furthermore, the elements of persecution based on ethnicity, religion, and belonging to a certain group provide sufficient grounds for Rohingyas to be recognised as refugees under the 1951 *Geneva Convention Relating to the Status of Refugees*. However, their statelessness has frequently been overlooked, although the *Convention Relating to the Status of Stateless Persons* was drafted in 1954. Statelessness is a primary concrete example of the discrimination faced by the Rohingyas in Myanmar, and the persecution determines their status as refugees. In particular, the condition of statelessness has detrimental consequences for individuals defined as “a person who is not considered a national by any State under the operation of its law” (*Convention Relating to the Status of Stateless Persons*, 1954, art. 1). Many stateless individuals remain in a state of protracted displacement.¹⁰⁸ As Rohingyas are stateless in a world of nation-states (Chaudhury & Samaddar, 2018, p. 2), they are not automatically protected against the penalisation of illegal entry or stay in another country.¹⁰⁹ Subsequently, the unique solution for them is to have a legal status recognised or obtain a specific nationality. To avert such

¹⁰⁸ The United Nations High Commissioner for Refugees coined the term “protracted displacement” to describe “refugee populations of 25,000 persons or more who have been in exile for five years or longer in developing countries” (UNHCR, 2004, p. 2). This definition, which classifies protracted displacement both in terms of time and quantity, applies to all Rohingyas in Bangladesh, in both cases of refugees who arrived in the country before and after 1991.

¹⁰⁹ In India, under the violation of the 1946 *Foreigners Act*, and the 1929 *Passport Act*, Rohingyas are often arrested (Chaudhury & Samaddar, 2018, p. 14).

scenarios, the 1961 *Convention on the Reduction of Statelessness* promoted the acquisition of nationality at birth, which has rarely been implemented.

The United Nations High Commissioner for Refugees (UNHCR) seems to offer another alternative. However, its *Framework for Durable Solutions* has attracted criticism in both general and specific terms. All three durable solutions have encountered serious challenges to implementation - i.e., (1) local integration in the host country, (2) resettlement in a safe third country, (3) and voluntary return to the country of origin (*Framework for Durable Solutions for Refugees and Persons of Concern*, 2003; Long, 2014). Consequently, the majority of refugees are trapped in a “long-lasting and intractable state of limbo” (Long, 2014, pp. 476, 477). For instance, (1) the dimension of local integration has been questioned by countries in the geographical Global South due to obligations, exacerbated tensions with local people, and an increase in the number of refugees (Moretti, 2021, p. 221). Bangladesh has demonstrated no official intention to allow Rohingyas to integrate locally. As a result, since 2018, the government of Bangladesh has enforced substantial measures to implement the “encampment policy”. The camp area was physically delimited with fences, and Rohingyas living in the camps were not allowed to leave. Moreover, Rohingya children have been denied the opportunity to enrol in Bangladeshi schools.

(2) Resettlement programmes from Bangladesh to third countries were available in 2006 but just for a small group of “vulnerable” people among the registered Rohingyas, and this opportunity was withdrawn in 2010. In 2006, twenty-three refugees were resettled to Canada, and seventy-nine in 2007 (Phiri, 2008, p. 34). Further resettlements were planned with the UK and New Zealand for 2008 (Phiri, 2008, p. 34), but never took place. In the *Third World Approaches to International Law Review*, authors like Tinmaing and Kanji (2020) criticised resettlement in a third safe country because resettling Rohingyas would support Myanmar’s objective of depopulating Rakhine State. Furthermore, the international community has played a complicit role by collaborating, more or less directly, with the Burmese regime by ignoring what many now recognise as an ongoing genocide (Tinmaing & Kanji, 2020, p. 8). Despite the increasing concerns about an ongoing genocide, the international community has neither challenged Myanmar’s sovereignty nor pursued the enforcement of human rights.

Ultimately, Chimni (1998) explains that since the end of the Cold War (3) voluntary repatriation has replaced resettlement in the application of UNHCR’s sustainable solutions.

¹¹⁰ In line with a global containment strategy – which has been the most convenient solution for the geographical Global North - this system of durable solutions relies entirely on voluntary repatriation by emphasising the responsibility of the state of origin (Chimni 1998, p. 369). While “returns” from Bangladesh have been cyclically legitimised for Rohingyas, this approach violates the principle of non-refoulement, which should prohibit the rejection of individuals at the border (Chimni, 1998, p. 365). This has been the case for many asylum seekers from “Indochina” who were deemed “non-genuine” refugees (Davies, 2008) and for Rohingyas who were forcefully returned from Bangladesh to Myanmar (Leider, 2020). If Rohingyas are returned each time they seek shelter in Bangladesh, they will migrate again. As a result, Rohingyas have experienced multiple episodes of forced migration.

The debates on international protection and its application in the geographical Global South for stateless people like the Rohingyas appear to be a dead-end street. As noted by Chimni (1998), studying each national context of refuge is far more useful for further research in Asia. Furthermore, most studies on Rohingya migration have focused on persecution, their migration to other countries, and how Rohingyas cope with forced migration. Therefore, research might consider investigating a wider range of experiences and collecting ethnographic materials, especially from the perspectives of marginal Rohingya individuals in each context of shelter.

6. Concluding Remarks

During and after the partition process, new Asian countries, including Burma, India, and (“West” as well as “East”) Pakistan, sought to remove minorities from their national territories. National regimes perceived minorities in border areas as disloyal. Burmese troops intervened in 1948 and 1949 against separatist groups in Arakan, and led to the first group of 5,000 people fleeing to Bangladesh. The Mujahid insurrections from 1949 to 1961 led again to confrontations, and in 1959 between 13,000 and 17,000 people fled and took shelter in today’s Bangladesh. Rohingyas experienced forced migration as a result of the clashes with the authorities intervening in Arakan, and each migration was followed by return programmes. Authorities introduced the idea of “irregular migrants” in the country and legitimised the military’s aggressive intervention in 1978, leading again to the forced migration of 250,000 people from Arakan. On the basis of the “Myanmarisation” nationalist

¹¹⁰ Between 1912 and 1969, nearly 50 million European refugees were resettled in a third country. Nowadays, resettlement has become a solution only for vulnerable refugees like single-parent family or those with special needs (Chimni, 1998, pp. 363-364).

process, some notions on race from the colonial period were adopted by those in power to legitimate the stripping of Rohingyas' citizenship. Arakan was repeatedly militarised, and Rohingyas' lands were confiscated. Ever-growing episodes of harassment spread out in Rakhine State leading to the forced migration of Rohingyas who took shelter again in Bangladesh in 1991 and 1992. Once more, returns were implemented despite people's unwillingness to do so. Rohingyas either migrated to other Arab countries or those who came back to Myanmar soon crossed the border to reach Bangladesh once more. In 2012, 2016 and 2017, Rohingya forced migration took place again in violent circumstances, persecution and Islamophobic discourses. Research on Rohingya forced migration has focused on recurrent topics, like genocide and debates around international protection. These works are important to grasp the various levels of exclusion affecting the Rohingyas. Reference to these contributions is crucial to study the legal context for Rohingyas in Bangladesh, as well as to conduct an ethnography of the camps.

Criminalisation and persecution of certain population sections, such as the Rohingyas, were often reinforced during processes of general partition and nation-building. The term forced migration has shed light on the historical dimensions that triggered the displacement of Rohingyas, as well as opened doors to touch upon different topics of discussion in the legal domain affecting Rohingyas.

CHAPTER FOUR Emic Categories Within Refugee Law

In Bangladesh, in the two old camps, the government has recognised 34,665 Rohingyas as refugees (Arif, 2020, p. 856) ¹¹¹ who are also often referred to as “registered refugees”. How can this be even conceivable in a country that has not signed the 1951 *Geneva Convention Related to the Protection of Refugees*? This chapter presents the main contributions theorising the understanding of refugee-related law in Asia, where most displaced people are not recognised as refugees. On the basis of the broader Asian debate on refugee law, it attempts to answer the question by exploring the origin of the category “registered refugees” and other names used among Rohingyas, NGOs and governmental officers in Bangladesh. Then, it examines different legal sources that might legitimate some forms of protection and respect for certain rights in Bangladesh. Contributions in the legal domain of international protection, ¹¹² international conventions, regional instruments and national laws have been fundamental for this chapter. This chapter refers to Chimni’s proposition of analysing each forced migration in its own circumstances (Chimni, 2009), and it aims to make the most of the contribution that anthropology can provide to the study of Rohingyas in Bangladesh through emic categories.

1. Refugee-Related Law in Asia

Countries in Southeast and South Asia have not adhered to the system of refugee rights protection, primarily represented by the *Geneva Convention Relating to the Status of Refugees*, because many were undergoing crucial nation-building processes when the Convention was drafted in 1951 within the context of the Western post-war period. ¹¹³ ¹¹⁴ The 1967 *Protocol Relating to the Status of Refugees* has removed the temporal and geographical limitations initially envisaged in the Convention, but this did not have any impact on the reluctance of Asian states to accede to it (Banerjee, 2014, p. 614).

¹¹¹ Elsewhere, a different figure of 20,000 registered refugees is mentioned (Guhathakurta, 2017, p. 651). In this case, figures differ from year to year. 34,665 were the registered refugees in 2017, while 20,000 may correspond to the number of registered refugees in 1991-1992.

¹¹² Arif, 2020; Banerjee, 2014; Barbour, 2021; Chimni, 2009; M. S. Hossain, 2021; Janmyr, 2021; Kneebone et al., 2024; Moretti, 2021; Rajan & Kumar, 2023.

¹¹³ Only China, Cambodia, South Korea and the Philippines have signed the 1951 Convention.

¹¹⁴ The international framework of the 1951 Geneva Convention is based on negotiations between the United States and international institutions, such as the International Labour Organisation (ILO) and various branches of the United Nations (Karatani, 2005, p. 518). This discussion excluded Asian and other non-European countries.

The management of international relations also requires anthropological explanations that consider so-called Asian values, such as deference to authority, collective interests over individual rights, and the Association of Southeast Asian Nations (ASEAN) principle of non-interference in the affairs of other countries (Moretti, 2021, p. 223). The principle of socio-economic cooperation based on respect for sovereignty and non-interference in the internal affairs of member states is fundamental in the South Asian Association for Regional Cooperation (SAARC) too (Z. S. Ahmed, 2019; Rajan & Kumar, 2023).¹¹⁵ Another reason for the widespread official rejection of the Refugee Convention in Asia is that countries prefer to avoid the additional responsibilities arising from its ratification (Vijayaumar, 2001).

Furthermore, some countries justify their non-signatory stance by citing certain ineffective technicalities (Vijayaumar, 2001, p. 7), like the temporary nature of the United Nations High Commissioner for Refugees, UNHCR (Moretti, 2021, p. 218). This approach leads to a “bureaucratic insensitivity” that, coupled with a “lack of political will”, motivates South Asian countries’ decision not to accede (Vijayaumar, 2001, p. 7). Lastly, establishing a “refugee status determination” (RSD) procedure is a considerable cost for the state, particularly because a section of the 1951 Convention privileges individual applications rather than group-based determination – i.e., *prima facie* refugees.¹¹⁶ These points are essential to consider in countries like Bangladesh hosting a vast number of refugees. A group-based determination procedure could be more realistic for the state to manage than an individual one.

¹¹⁵ All SAARC members participated in the Asia-Pacific regional forum in 2002, which focused on the Bali Process on People Smuggling, Trafficking in Persons and Related Transnational Crime. Besides, in 2016, the SAARC countries signed the *New York Declaration for Refugee Migration* and consented to the necessity for regional instruments to tackle issues of forced displacement (Ahmed, 2019, p. 214). Bangladesh, India, and Pakistan participated in the regular meetings of the UNHCR’s Executive Committee in Geneva but have never formulated a unified vision in the domain of refugee-related law (Ahmed, 2019, p. 215). There has been no significant effort to collaborate among the SAARC members due to the power imbalance between India and the other SAARC countries (Bhattacharjee, 2018; Rajan & Kumar, 2023, p. 220).

¹¹⁶ In fact, the 1951 Convention does not directly use the term *prima facie*, but *prima facie* determination of refugee status is founded in the Convention (Albert, 2010). On the basis of the principles of general human rights law (to be found in (a) the 1969 *Vienna Convention on the Law of Treaties*, and (b) litigation before the International Court of Justice), the granting of a legal status shall be accorded through due process and therefore not be withheld for an unreasonable period. The domestic legislation in countries like Kenya, Sierra Leone and Burundi, expressively codifies the recognition of *prima facie* refugee status (Albert, 2010, p. 30). Finally, the UNHCR Handbook states under paragraph 44: “While refugee status must normally be determined on an individual basis, situations have also arisen in which entire groups have been displaced under circumstances indicating that members of the group could be considered individually as refugees. In such situations the need to provide assistance is often extremely urgent and it may not be possible for purely practical reasons to carry out an individual determination of refugee status for each member of the group. Recourse has therefore been had to so-called ‘group determination’ of refugee status, whereby each member of the group is regarded *prima facie* (i.e. in the absence of evidence to the contrary) as a refugee” (*Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol Relating to the Status of Refugees*, 2019, p. 20).

Some scholars addressed the topic with the expression “Asian approach” or “Asian exceptionalism” to underline the non-interference of Asian countries in questions regarding the national sovereignty of others (McConnachie, 2014, p. 627; Moretti, 2021; Vijayaumar, 2001). Chimni (2009) criticises this notion, which originates from a Western approach and overlooks the circumstances of forced displacement in the region. He suggests analysing each scenario separately, as each scenario stands on its own conditions and contexts (Chimni, 2009).

Authors like Abrar (2001) asserts that, first and foremost, South Asian countries should approach refugee issues by dissociating them from security concerns and view them as matters of humanitarian rights (Abrar, 2001, p. 21).¹¹⁷ Despite calls from several authors for legislation to protect refugees in the region (Abrar, 2001; Rajan & Kumar, 2023), the reluctance of Asian states to develop such a system has also prevailed, following the recent restrictive asylum policies in the United States and Europe. In fact, the common Asian response to forced migration has been directed at preserving diplomatic relations and resolving displacement through bilateral agreements (Moretti, 2021, p. 225).

The legal scholar Hossain (2021) argues that some practices in Bangladesh are legitimate and still provide protection to refugees despite the country having neither signed nor ratified the Geneva Convention. For example, the principle of non-refoulement and the duty of non-penalisation for irregular entry are two aspects of international law that are usually respected (Moretti, 2021, p. 236). Barbour (2021) draws the reader’s attention to the contributions of *Third World Approaches to International Law* and other scholars, who rearticulate the discourse by claiming that refugee protection in Asia is situated between humanitarianism and a certain idea of sovereignty (Kneebone et al., 2024). Another significant perspective is provided in the doctoral thesis of Louise Perrodin at the University of Paris. Perrodin investigates the hypothesis that the usage of international law by “marginal actors” like Rohingyas in Malaysia redefines the understanding of law and power relations, especially in a context like Malaysia where the 1951 Geneva Convention has not been signed (Perrodin, 2024). Starting from this debate, emic categories are crucial to explore exclusionary dynamics and policies affecting Rohingyas in Bangladesh.

¹¹⁷ The UNHCR established the consultations of the *Eminent Persons Group for South Asia*, which included former government officials, judges, lawyers, academics, and journalists from South Asia (UNHCR Global Report, 2001, p. 306). During annual meetings, the EPG discussed either accessing the 1951 Geneva Convention or creating a regional instrument for the area. In 1997, it deliberated on a model law for refugees to implement at a national level (Abrar, 2001, p. 23).

2. Registered and Unregistered Refugees: Emic Categories and Migration Policies

Recently arrived Rohingyas are registered as “Forcibly Displaced Myanmar Nationals” in Bangladesh, and are commonly known as “unregistered refugees”. In Bangladesh, the use of categories does not emerge solely from refugee-related international legislation, although this impacts people’s lives. One of the most common categories, for instance, mainly used by humanitarian workers in fact originates from governmental policies: the terms “registered” and “unregistered refugees”.

A pertinent explanation of these categories comes from a Bangladeshi NGO worker.

“The government of Bangladesh admitted that granting refugee status to people from Kutupalong and Nayapara ¹¹⁸ was a poor decision because people now have more demands and repatriation is not easy to accomplish with ‘registered refugees’.[...] The registered refugees own the land, while the unregistered people do not belong here. It is a matter of power. Besides, registered refugees consider themselves ‘elite people’, especially after 2017 when they received better services following the new arrivals.”

(W., personal communication, 7 April 2022)

This perspective defines that “registered refugees” are Rohingyas who arrived in Bangladesh in 1991 and have never been sent back to Myanmar. They currently reside in two camps, commonly referred to as “registered camps” or “old camps”. Furthermore, his point of view acknowledges the popular (and, to some extent, official Bangladeshi) narrative that the government “did wrong” by recognising the old Rohingyas as “registered refugees”, as this has granted them rights and generated greater demands. For instance, the government has never repatriated them. The interlocutor describes registered refugees by stating that they “own the land”. Although this is not entirely accurate, it contains an element of truth. Registered refugees do not own the land; they have lived in the same area for so long that, for many local people, it is unlikely they consider them residents of any other area in the country. Finally, since 2017, they have received better services, which refers to the increase in funding for the Rohingya humanitarian response. At the same time, registered refugees have experienced some extreme shifts in their living conditions. Due to a change in policy and the construction of thirty-two camps, new measures have been implemented, such as a different approach to camp management, deforestation, mobility restrictions

¹¹⁸ Kutupalong and Nayapara are the names of the two old camps, established in 1991.

outside the camp area, a ban on education, and a stricter prohibition of work. Therefore, the categories of registered and unregistered refugees, which are theoretically irrelevant in the legal domain, show a substantial difference among the Rohingyas. One group has been living in the camp area for more than thirty years, whereas another arrived in Bangladesh in 2017 when the government restricted life in the camps.

Registered refugees mention to me that, at the beginning of their stay in Bangladesh, travelling to Saudi Arabia with a fake passport for reasons of pilgrimage used to be very common (sometimes followed by staying on in the country) through the mediation of brokers, who were able to secure a visiting visa. They narrate that migration used to be less critical at the time than it is today, as borders used to be less controlled and workers were easily accepted in Bangladesh and other countries like Saudi Arabia.

As described by the same humanitarian worker, the change in policy is mirrored in the new political terminology used to refer to other Rohingyas:

“Those without status, namely FDMN, are referred to by ‘a word from politics’ and could be sent back more easily.”

(W., personal communication, 7 April 2022)

The humanitarian worker highlights the 2017 strategy of not labelling individuals with the term “refugees”. Instead, they are referred to with “a word of politics”, namely “Forcibly Displaced Myanmar Nationals” (FDMN). This designation is often criticised among the Rohingyas, particularly in comparison to the previous recognition by the government of registered refugees.¹¹⁹ The political shift in government policy is reflected in the categories used by NGOs and local authorities, which address “registered refugees” differently from the rest who, in a sort of opposition, are called “unregistered refugees” or “FDMN”. Furthermore, this division is reiterated through two other names: “old Rohingyas”¹²⁰ and “new Rohingyas”.

In a country lacking national refugee law and related terminology, the institutional categories used by Rohingyas sometimes acquire new meanings. More precisely, from the perspective

¹¹⁹ Theoretically, the category “Forcibly Displaced Myanmar National” should not be totally condemned since it reflects the Rohingyas’ legitimate claim to citizenship in their homeland from which most of them were forcibly displaced.

¹²⁰ Registered refugee, old refugee and old Rohingya are synonyms.

of the old Rohingyas, the term “registered refugee” was equated with the idea that should they return to Myanmar, they would risk their lives. Registration implied the risk of being identified and hence exposed to death in Myanmar.¹²¹ More specifically, during the years of returns in the 1990s, some families decided not to collect their “data card”¹²² (also called “family book”) for fear of or to protest against repatriation (Médecins Sans Frontières Holland, 2002, p. 13). Registered refugees told me overwhelming stories of the multiple attempts of the government of Bangladesh to repatriate them to Myanmar and their resistance throughout the 1990s. This contrasts with the image of vulnerable refugees: registered refugees frequently described themselves as the “ones who made it”. As strong supporters of the refugee cause, they resisted the attempts made by the government of Bangladesh to repatriate them. The registered refugees emphasised on several occasions that the authorities in Bangladesh have never succeeded in taking their fingerprints or retinal scans. Indeed, they refused all forms of such physical registration and control techniques.

Group designations and names reflect the existence of boundaries among people. Not only have registered refugees received assistance since 1991, they also have established a monopoly over specific activities in the camps like managing the nearby markets. In other words, the difference between Rohingyas who have been residing for a protracted period and those who arrived in 2017 can be expressed in terms of resources. Registered refugees have long had the opportunity to attend schools and learn the local language. In contrast, new refugees were deprived of these opportunities because the encampment policy was enforced more strictly when they arrived, and they were not permitted to leave the camps as easily. The enduring presence of refugees in the country may constitute a resource, potentially providing them with a common basis for belonging to the local people (Ferguson, 2019). Nevertheless, registered refugees are not the only Rohingyas familiar with local customs.

The terms “registered” and “unregistered refugees” are also used among Rohingyas, but they do not always correspond to other emic designations. Emic categories are valuable for examining how the Rohingyas view their stay in Bangladesh and for describing their relationships with other social actors.

¹²¹ Similarly, Chatty (2010) explained that some refugees in Lebanon preferred not to live in camps due to their fear of being registered.

¹²² The data card is a sort of identity card for Rohingyas and is used to gain access in the camps to various services such as food distribution.

Several Rohingyas in the old camps recount their interactions with Bangladeshis using the term *boingas*. Broadly used in Chittagong to denote Bangladeshis residing in the country but outside the Division of Chittagong, the term bears a more specific meaning within the camps. It negatively represents Bangladeshis who, after travelling to Europe, have attempted to present themselves as Rohingyas during the status determination procedure to receive international protection.¹²³ Besides, this term refers to Bangladeshi people, but not to *Chittagonians* who would never betray Rohingyas, thus emphasising the Rohingyas' proximity to local people. Chittagonians use other terms to refer to Rohingyas like the term *jerbadi*, which refers to the old refugees with a connotation depicting them as determined to achieve their interests. *Jerbadi* is mentioned in chapter 2 as a way to refer to the children of Muslim Indian men and Buddhist Burmese women in Rakhine State (Yegar, 1972, p. 33).

A female research participant named Moriam tells me about two other terms: *qwesha* and *wessa*.¹²⁴ These words highlight a difference that is less epistemological and more factual concerning the Rohingyas' access to material resources. Literally, *wessa* refers to those living in poverty. Most Rohingyas live in camps where they periodically receive food rations, access to healthcare services, water and gas as basic provisions of the humanitarian response. In this way, they automatically access such resources, but it is hard for them to compete in the labour market. Moriam uses these words that originate from Chittagong local language to describe herself and other Rohingyas as she arrived in Bangladesh in 2012 and settled in a makeshift settlement next to an old camp. She describes herself using this notion of poverty because she was not provided with humanitarian assistance upon her arrival in Bangladesh, but she has been in close contact with local people. She had to manage her life on her own for less than a decade. In other words, she had to live in poverty until 2017. By contrast, *qwesha* indicates people who live in comfort. The word is used for those Rohingyas who arrived in 2017 to describe how, upon their arrival in Bangladesh, they have received support from various international and local NGOs. Instead, the *wessa* have experienced poverty below the standard of life in refugee camps and this has triggered tensions with the registered refugees in the past.

As Roshida, another woman living in the informal settlement camp, recalls:

¹²³ The name *boinga* and its similarity in sound with the word "Rohingya", apart from the first letter "b", might indicate the practice of Bangladeshis who try to gain refugee status by addressing a fake identity as Rohingyas.

¹²⁴ The terms originate from the Chittagong dialect, in which *qwesh* is commonly used as an adjective meaning "comfortable". For example, *qwesh gori boion* translates to "sitting comfortably". Instead, *wessa* is a noun and refers to a person who is starving.

“We did not get the Myanmar Refugee Card because we were living in the village. From there, we contacted some relatives who, at the time, were living in the registered camp. Our relatives didn’t give us the shade number (i.e., shelter number), although, at the time, this was necessary to get the card. So, despite the fact that the community of the registered camp was supportive in helping us settle next to them, I didn’t get any card. In 2005, many were in the same situation. We didn’t get any donations due to the lack of a proper shade number. Therefore, the government called us outsiders.”

(R., personal communication, 18 April 2022)

After 2005, when the forced repatriations of the majority of Rohingyas were completed, institutions in Bangladesh distributed the Myanmar Refugee Card to registered refugees, while ignoring that relatively smaller groups of repatriated Rohingyas had returned and settled in the area surrounding the two old camps. The term “registered” probably originated from this card. This document was denied to other Rohingyas who settled in the informal settlements next to the two registered camps, leading to tensions between the two groups of Rohingyas who were nonetheless related. In this manner, families were fragmented as registered refugees supported those other Rohingyas excluded from the old camps only to a certain extent.

From the conversations with Rohingyas, it looks like registered refugees might have shared food and goods with other Rohingyas, but not documents. Nevertheless, as described by Yasmin, who has also been living in Bangladesh since 2010, the differences between the *wessa* and the registered refugees have recently faded:

“The registered [refugees] told us that we have no land to live on, whereas the *qwesha* told us that we got food thanks to them [...] Now we are all the same; we are all getting the same rations, but earlier, they [registered refugees] used to neglect us. We are all getting the same rations now, and thus, the new refugees are marrying old Rohingyas. So, we are all the same.”

(Y., personal communication, 20 April 2022)

Yasmin’s words highlight the boundaries among different groups of Rohingyas: the registered refugees, the *qwesha* and the *wessa*. Yasmin describes her condition like other *wessa* who have been between a rock and a hard place. Registered refugees claim their position, given the long stay in one camp area for three decades, and the *qwesha* argue that

only after their arrival humanitarian resources have been distributed to all Rohingyas. The wessa have not gained access to camp services and humanitarian aid for a long time.

Given the absence of refugee law in the country and the changes in its official policies regarding the Rohingyas, it is crucial to bear in mind that registered refugees have faced situations where they have been excluded from refugee rights over the past thirty years. For instance, resettlement programmes were launched in their camps to transfer a few individuals to third countries, only in cases of “vulnerabilities” (such as physical or mental disabilities), but these programmes were soon closed. Experiences of exclusion have changed over time for refugees and might be described differently according to the perspective taken into consideration.

3. Refugee-Related Law in Bangladesh

Legally speaking, Rohingyas are not recognised as refugees in Bangladesh. However, the group of registered refugees remains a point of contention in international law. Still, there are several legal grounds that could be compared to different “laws” governing the order of refugee camps. Similarly, *the Encyclopedia of Anthropology* identifies three phases in which anthropology has dismantled any simplistic understanding of law as a system of rules regulating lives. (1.) The unity of law has been interpreted as mirroring certain features of society and the relationship between people’s milieu and law (Vincent, 2002, p. 499). (2.) Anthropologist Max Gluckman examined codified rules that aimed at establishing order in social interaction (Gluckman, 2012); (3.) Action-oriented and processual anthropology brought attention to courts and legal procedures. Moreover, different interpretations of law emerged on a regional level, and Africanist and Arabist studies have focused on the role of indigenous and customary law. During colonialism, customary law defended local autonomies and subsequently legitimised or accompanied the process of nation-building. The discipline of legal anthropology concentrates on historical analysis and the influence of politics on law implementation. Foucault’s *Discipline and Punish* is an important reference for understanding law as a form of surveillance and control (Foucault, 1977).

Religion should be addressed briefly, as it plays a crucial role in the government of Bangladesh, particularly concerning its humanitarian responses (a.) the Rohingya Refugee Response, which has been the main policy since 2017, and (b.) the 2013 adoption of its first National Strategy on Myanmar Refugees and Undocumented Myanmar Nationals. The latter is unfortunately not accessible but consists of governmental engagement in providing basic medical care, potable water, sanitation facilities, and other essential humanitarian services

to undocumented Rohingya, as well as it envisaged diplomatic engagement with Myanmar for repatriation (Khan & Rahman, 2020).

In Islam, forced displacement has theological resonance since the Prophet Muhammad in 622 (Common Era) had to leave his hometown of Mecca and find asylum (*Hijra*) in Medina - then al-Yathrib (Benthall, 2011, p. 104). Additionally, according to Islamic Law (*Sharī'a*), refugees are eligible for *zakāt* (in Bangladeshi: যাকাত or জাকাত, *zakat*), which is a way to redistribute wealth among the Muslim community of believers (*‘umma*) beyond borders (Benthall, 2011, p. 104). At the beginning of 2017, under the Rohingya Refugee Response, the government of Bangladesh indeed supported the policy of giving shelter based on the common narrative of solidarity within the Muslim community (Lewis, 2019) since Islam requires its followers to offer asylum. Such an approach, which I would define indeed as giving “asylum”, has collided with the recently promoted migration policies that, including returns and relocations, involve much more the idea of “refuge”.¹²⁵ In other predominantly Muslim countries like Indonesia and Malaysia, Rohingyas have been received on the grounds of religious solidarity which has faded in recent years.¹²⁶

On the basis of customary law, Rohingyas are protected from refoulement, especially following the 2017 ruling by the Supreme Court of Bangladesh. Another relevant legal source in this analysis is court decisions, as in a common law system inherited from British colonial rule, jurisprudence derived from court decisions is considered part of (precedent) law. In 2017, the Supreme Court of Bangladesh declared that a Rohingya held in jail, even after completing his prison sentence, might be endangered if he were to return to Myanmar. The Court proposed that the defendant should be released and accommodated in a refugee camp based on the *Convention Against Torture and its principles (Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment, 1984)*.¹²⁷ Moreover, the Court supported this decision by referencing the 1951 Convention, to which the country is not a member but which has become part of customary law and court-issued jurisprudence. The Court specified that customary law in the Bangladeshi Constitution is

¹²⁵ Despite the extensive work already conducted by Jeff Crisp on the matter, who has worked for the UNHCR and is a research associate at the Refugee Studies Centre in Oxford, further research should be conducted on the migration policies and so-called voluntary return of Rohingyas. Besides, further investigations could expand on the different meaning of asylum and refuge, as well as the religious dimension of shelter, also in relation to the presence of Christian and Hindu Rohingyas in Bangladesh.

¹²⁶ See recent Rohingyas' imprisonments in Malaysia and pushbacks in Aceh, Indonesia.

¹²⁷ *Refugee and Migratory Movements Research Unit (RMMRU) v Government of Bangladesh, petition no. 10504 of 2016*, Bangladesh: Supreme Court, 31 May 2017, available at: <https://www.refworld.org/jurisprudence/caselaw/bansc/2017/en/122883>. Last accessed on 17th July 2024.

governed by Article 145 A.¹²⁸ Although Hossain (2021) pointed out that there is no constitutional provision on how to enforce so-called customary international law, this should not be regarded as a relevant argument, as the treaty does not conflict with the fundamental principles of the Constitution, establishing the respect of “human rights, freedom, and the dignity of the human person” (*The Constitution of the People’s Republic of Bangladesh*, 1971, art. 11):

“Though Bangladesh has not formally ratified the Convention relation to the Status of Refugees, yet all the refugees and asylum-seekers from scores of countries of the world to other countries have been regulated by and under this Convention for more than 60 (sixty) years. This Convention by now has become a part of customary international law.”¹²⁹

This decision marks a significant milestone in safeguarding refugee rights in Bangladesh, as it reaffirms the commitment to upholding the fundamental principles of refugee law. Furthermore, all treaties signed and ratified by the country, along with its national laws and norms classified as general international law (*jus cogens*), presuppose the state’s consent to the ensuing obligations.

The majority of Rohingyas still reside in refugee camps and find themselves in a situation of protracted displacement in Bangladesh. Still, they have certain guaranteed rights. Unlike Thailand’s illegitimate incarceration of several refugees due to their illegal entry, Bangladesh has not systematically imprisoned Rohingyas.¹³⁰ Neither has Bangladesh repatriated Rohingyas against their will in recent years before 2024, in contrast to India. Even though the governments of Bangladesh and Myanmar have signed several agreements to repatriate Rohingyas, who have consistently expressed their concerns about returning, repatriation has not taken place recently.¹³¹ ¹³² Therefore, a certain extent of legal protection for them is related to the country’s involvement in international treaties and to national principles being observed.

¹²⁸ “All treaties with foreign countries shall be submitted to the President, who shall cause them to be laid before Parliament: Provided that any such treaty connected with national security shall be laid in a secret session of Parliament” (*The Constitution of the People’s Republic of Bangladesh*, 1971, art. 145 A).

¹²⁹ *Refugee and Migratory Movements Research Unit (RMMRU) v Government of Bangladesh*, petition no. 10504 of 2016, Bangladesh: Supreme Court, 31st May 2017, available at: <https://www.refworld.org/jurisprudence/caselaw/bansc/2017/en/122883>. Last accessed on 17th July 2024.

¹³⁰ Human Rights Watch, 2022.

¹³¹ In contrast with these tendencies, the interim government of Muhammad Yunus has counterbalanced this trend by accomplishing forced returns (Fortify Rights, 2024b).

¹³² Fortify Rights, 2023b.

The absence of asylum legislation should not necessarily be interpreted as an aggravation of, but as a layer to analyse social exclusion. Bangladesh signed the *Universal Declaration Bill of Human Rights*, the four Geneva Conventions of 1949 and their two Additional Protocols of 1977. It is a party to other international human rights instruments, such as (1) the *Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment* or CAT (1984), (2) the *Convention on the Elimination of All Forms of Discrimination against Women* or CEDAW (1979), and (3) the *International Convention on the Elimination of All Forms of Racial Discrimination* or CERD (1965). The country is also a party to the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* or CMW (1990), the *Convention on the Rights of the Child* or CRC (1989), and the *Convention on the Rights of Persons with Disabilities* or CRPD (2006). As Arif (2020) points out, these instruments establish a framework of obligations for the country to protect refugee rights, particularly based on Article 2 of the *International Covenant on Civil and Political Rights* or ICCPR (1966), which asserts that foreigners enjoy the same fundamental rights and freedoms as nationals. Despite being encouraged to ratify the 1951 *Convention Relating to the Status of Refugees* (and its 1967 Protocol), the 1954 *Convention Relating to the Status of Stateless Persons*, and the 1961 *Convention on the Reduction of Statelessness*, Bangladesh has not made any decision in this regard. However, the country is generally influenced by the 1951 Convention. As Janmyr (2021) notes:

“In May 2018, Bangladesh explained that it ‘is not a signatory to the 1951 Refugee Convention, yet Bangladesh has long been hosting refugees and forcibly displaced Rohingyas from Myanmar with full respect to international protection regime’.” (205)

This approach was also confirmed by the Supreme Court decision in 2017. Furthermore, the UNHCR initiated its relationship with Bangladesh in 1971, the year of the country’s independence (Janmyr, 2021, p. 202). The UNHCR has consistently played a compliant role with the government, fearing that its presence would be questioned and it would be expelled

from the country. This characteristic applies not only to the UNHCR but also to many working NGOs in the country.¹³³

Under these premises and legal circumstances, restrictive government policies often undermine refugees' access to justice, despite the fact that the Constitution of Bangladesh asserts the rights to life and freedom for all individuals (Arif, 2020, pp. 864, 865). The following constitutional articles are fundamental to the protection of refugee rights in Bangladesh:

- "The State shall base its international relations on the principles of respect for [...] international law and the principles enunciated in the United Nations Charter" (*The Constitution of the People's Republic of Bangladesh*, 1971, art. 25).
- The principle of equal protection under the law for all (*The Constitution of the People's Republic of Bangladesh*, 1971, art. 27).
- The principle of equality and foreigners (non-citizens) who stay in the country are also entitled to the protection of the law (*The Constitution of the People's Republic of Bangladesh*, 1971, art. 31).
- "No person shall be deprived of life and liberty save in accordance with the law" (*The Constitution of the People's Republic of Bangladesh*, 1971, art. 32).
- Safeguards regarding the arrest and detention of any person (*The Constitution of the People's Republic of Bangladesh*, 1971, art. 33).
- Prohibition of all forms of forced labour (*The Constitution of the People's Republic of Bangladesh*, 1971, art. 34).
- Protection for all persons with respect to the trial (*The Constitution of the People's Republic of Bangladesh*, 1971, art. 35).

¹³³ One example is useful to clarify this scenario. As a retired UNHCR Bangladeshi employee explained to me in Dhaka, the Rohingya response started thanks to Médecins Sans Frontières (MSF) in February 1992 and the path has not been easy. In an informal conversation with Dr. Odile Marie Cochetel (a French citizen who had previously worked with MSF and was in the 1990s in Bangladesh due to her husband's work at the University of Chittagong) she recalled visiting the Rohingya camps and encountering in 1991 the diffused attitude of representatives of NGOs that, having been in the country for years, remained reluctant to propose an assistance programme for Rohingya refugees (Binet, 2020, p. 26). Their fear concerned that such programmes could have compromised their relations with the government and their projects in the country (Binet, 2020, p. 26). This atmosphere influenced UNHCR's presence in the country as well. In December 1991, therefore, Dr. Odile Marie sent a report to the headquarters of Médecins Sans Frontières France, which, since it did not have any project in Bangladesh yet, agreed to launch an assistance programme for the Rohingyas (Binet, 2020, p. 25). As the former UNHCR Bangladeshi employee recounted, when Médecins Sans Frontières France sent a chartered aircraft to Chittagong in February 1992, the Bangladeshi authorities objected to its landing, which took place only days later thanks to the mediation of Danielle Émilienne Isabelle Mitterrand, wife of then French President François Mitterrand (Binet, 2020, p. 26).

As Arif (2020) comments, the encampment policy does not allow freedom of movement for Rohingyas, who are prohibited from working outside the camps and thus risk becoming illegal if they do. Within the current implementation of migration policies, Rohingyas are unable to fully enjoy basic rights in the country.

The 1946 *Foreigners Act* is a national legal instrument that serves as a valuable example for analysing how colonial regulations continue to affect refugees in Bangladesh. Generally, it defines a foreigner as “a person who is not a citizen of Bangladesh”, thereby including refugees (*The Foreigners Act, 1946, 2 a*).¹³⁴ It regulates the entry, stay, and exit of foreigners. Section 3 empowers the government to control the mobility of foreigners within the country (*The Foreigners Act, 1946*). This Act and other legal instruments¹³⁵ were drafted during the first British colonisation and later Pakistani domination. As Arif points out, given the absence of national refugee-related legislation, all foreigners in Bangladesh are, in practice, treated under inadequate laws that do not meet people’s needs and contradict constitutional principles (Arif, 2020, p. 866). In addition to the 1946 *Foreigners Act*, there are more recent legal instruments that are also relevant for refugees (Arif, 2020, p. 866).¹³⁶

More specifically, the 2004 *Registration of Births and Deaths Act* (জন্ম ও মৃত্যু নিবন্ধন আইন) entitles Rohingyas to birth and death registration. Article 3 states: “Births and deaths of any person has to be registered according to the provisions of this Act”, where “people” is defined in Article 2 as any Bangladeshi or foreigner living in Bangladesh (Arif, 2020, p. 867). The government of Bangladesh in 2017 complicated the process of issuing birth certificates and identity documents for the local population around Cox’s Bazar (Arif, 2020, p. 867). The official motivation for this was to prevent Rohingyas from obtaining fake identification documents (Arif, 2020, p. 867). The UNHCR and the Refugee Relief and Repatriation Commissioner (RRRC) started a joint registration of marriage and divorce in 2019 (Arif, 2020, p. 867). For instance, during my fieldwork, newborn children were issued birth certificates, but only if they were born at the camp hospitals.

¹³⁴ Act nr. 8 of 1973 substituted the words “Central Government” and “Pakistan” respectively with the words “Government” and “Bangladesh”.

¹³⁵ For example, the following laws are the main legal instruments that, drafted during colonial times, regulate refugees’ stay in Bangladesh. The 1908 *Code of Civil Procedure*; the 1920 *Passport Act*; the 1926 *Naturalization Act*; the 1939 *Registration of Foreigners Act*; the 1951 *Citizenship Act*; the 1952 *Control of Entry Act*.

¹³⁶ The 1972 *Bangladesh Citizenship (Temporary Provisions) Order*; the 1973 *Bangladesh Passport Order*; the 1974 *Extradition Act*; the 2004 *Births and Deaths Registration Act*; the 2013 *Children Act*; and the 2017 *Child Marriage Restraint Act*.

All these principles, laws, articles and legal provisions contradict the fact that Rohingyas are not legally recognised in Bangladesh.

4. Concluding Remarks

Like many other countries in Asia, Bangladesh does not recognise the refugee status of Rohingyas. The analysis of the national context reveals the existence of alternative practices to grant asylum in the country, based on systems such as religion, international human rights instruments, the constitution and national laws. Nevertheless, these systems are often hindered by migration policies. To analyse migration policies and the complex experiences of Rohingyas, emic categories are useful. For example, the category “registered refugees” has shown that the government of Bangladesh considered it a mistake to call the Rohingyas “refugees” in the 1990s. To offer refuge is important for Muslims, despite the international legal obligations that the term entails. Emic categories highlight the discourses around migration in the country, as well as the struggles of the Rohingya people, and their interactions with locals.

The absence of refugee law should not be interpreted as denying protection to the Rohingyas. Emic categories offer a key to understanding how diverse policies contribute to the social exclusion of Rohingyas.

Conclusion of Part One

Part one has illustrated the historical complexities that intertwined before, during, and after the colonial period in Arakan. In Asia, movements of people used to be more fluid, then they started being controlled. These complexities can be observed in the debate surrounding the origin of the name “Rohingya”. During nation-building processes in Asia, migration was tackled through nationalist policies that criminalised certain groups, especially in border regions. The term forced migration has been important to highlight that migration within the region has changed. Besides, it has emphasised the relevance of the historical process, but also the legal debates around Rohingyas. However, all this often lacks an ethnographic dimension. Part one argues that examining the legal debates surrounding Rohingyas is a crucial first step in exploring exclusionary discourses. Emic categories are crucial notions to understand differences among Rohingyas while analysing the historical and legal discourses about forced migration.

PART TWO. ETHNOGRAPHY OF THE CAMPS: MOBILITY, SOCIAL TIES
AND HUMANITARIAN RESOURCES FOR ROHINGYA WOMEN IN THE
FIELD OF REPRODUCTIVE HEALTH



5

Social Exclusion and Survival Strategies of Rohingya Refugees in Bangladesh

Valentina Grillo 

1 Introduction

This chapter examines the social exclusion experienced by Rohingya due to the segregation that forces them into refugee camps, where essential humanitarian services are not consistently provided. Consequently, the coping mechanisms activated by refugees are termed “survival” strategies. This contribution conceptualises “mobility” as more than just a restriction. Rohingya’s movements outside and within camps, combined with their local cultural knowledge and social ties, enable them to mobilise various resources. Mobility becomes a lens through which this contribution examines refugees’ exclusion and the strategies activated in the camps. It aims to challenge the typical image of refugees as victims and questions the idea that Rohingya are a homogenous group of Muslim

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89

Image 6: Page 89 of published chapter (Grillo, 2025).

¹³⁷ The present chapter has been drafted with the purpose of publication in the book *Reshaping Rohingya Futures: Coping Strategies and Emerging Agencies*, edited by Nasir Uddin (2025).

refugees from Myanmar.¹ Ultimately, it attempts to go beyond the binary opposition between refugees' agency and their victimhood, as illustrated through three camps.

The inhabitants of the first camp lived in an informal settlement in Bangladesh for a decade before being included in the humanitarian response in 2017. This camp is called "informal settlement camp", and its inhabitants rely on their immaterial knowledge of local practices to pursue their strategies. The first camp highlights survival strategies linked to external borders and internal borders. The second camp, which I refer to as the "old camp" because it is where Rohingya have been living for 31 years, showcases the crucial (and sometimes ambiguous) role of social ties with the local community, leading to different forms of mobilities. Finally, the new camp, remote from other camps, illustrates how isolation can be a resource for building social connections within the Rohingya "accidental community". This is called the "new camp" since Rohingya arrived in 2017.

All of a sudden, on a house's door, I read the writing: "Block D, Camp 6". Without noticing, we had crossed internal camp boundaries several times! While external boundaries are visible, divisions between camps are rarely indicated. Due to the invisibility of the inner borders, it is common practice to write on the doors of shelters both the number of the camp and the block. Occasionally, movements can be controlled at the checkpoint, but this rarely happens between camps. As soon as we realise that the internal borders are not as visible as the external ones, we began to heed camp boundaries.

While Rohingya had to work on survival strategies or needed valid reasons to cross external boundaries of the camps (like the check-post) because social exclusion was imposed on them by restricting their mobility, my research assistant, Tonmoy Chowdhury, and I were rarely asked to show our papers at the check-post.² The difference in treatment between me and the Rohingya made it clear that border enforcement in the camps reproduced and reflected this hierarchy (Khosravi, 2019, p. 121).

¹ Rohingya are part of a mainly Muslim minority from Myanmar, and there are also two smaller groups of Christian and Hindu Rohingya.

² During my fieldwork, Tonmoy Chowdhury (MA student in Anthropology at the University of Chittagong) assisted me for most of the time of my research.

However, the Rohingya who have gained more knowledge about the local culture can leave the camps.

The geographical proximity of Myanmar was mirrored by the fact that the Rohingya shared some cultural, religious, and social aspects with the local population. The Rohingya dialect closely resembled the local language of south-eastern Bangladesh, where the camps were mainly located, and many cultural traits were shared with the local Bangladeshi population. Also known as Chittagonians, the local people were keen to speak with me on the topic but ensured that I had a clear distinction in mind: they are different from Rohingya. Such an attitude of rejection redirected me even more closely to governmental migration policies. Migration policies demonstrated that Rohingya were not welcome to settle in the country and encouraged their return, which resonated in the discourses of local people. The Government of Bangladesh, legitimately challenged by single-handling this situation of mass displacement also due to its leading role in the humanitarian response, has taken a series of measures to restrict life in the camps. Therefore, it established stricter encampment policies so refugees could not move from the camps and did not intermingle with the population. To achieve this purpose more easily, external fences were built in 2020 during the COVID-19 pandemic, hindering refugees from exiting the camp area and interacting with local villagers. It seemed that Rohingya were no longer allowed to go out. Still, I met many Rohingya on my way back from the camps. Border enforcement appeared to be porous in these cases. Outside the camp area, I was allowed to ask questions about the exchanges between Rohingya and local people, whereas this topic was off-limits in the camps. To avoid the production of knowledge regarding interactions with the local population, the governmental office that issued my “permission to do research in the Rohingya camp area” explicitly forbade me from asking about the relationship between Rohingya and the Bangladeshi community.

During a one-year ethnographic fieldwork in Chittagong (south-east Bangladesh), I studied and observed the lives of Rohingya women in refugee camps through the lenses of legal and medical anthropology, alongside topics such as social exclusion, birth, and reproductive health. I accomplished this in three of the 33 refugee camps in Bangladesh that were opened under the national migration policy coupled with the

humanitarian “Rohingya Refugee Response”. I chose camps to explore migration both temporally and spatially. In other terms, I worked with refugees who arrived in Bangladesh in 1978, 1991–1992, 2012, and 2016–2017. I included camps located in very dense areas and bordering other camps, as well as isolated camps. Besides, I consciously included camps inhabited by both Rohingya and local Bangladeshi people who lived in the area where the camp was constructed, as well as camps where only Rohingya lived. These camps early featured as sites of exclusion. The ways of facing social exclusion were diverse, as were their migrations and the places where they lived in Bangladesh.

2 Theories on Social Exclusion in Refugee Camps

Exclusion can be defined as being negotiated through norms in a social or legal context. Specifically, exclusion is defined as “an outcome of practices by state and non-state actors that hinder migrants’ access to territory, rights and resources, as well as participation in societal spheres” (Foblets et al., 2018, p. 28). This definition of exclusion may appear as accentuating the passive role of migrants; however, this is not the aim of the scholars who identify “acts, actors, areas, moments, representations, and reactions” as the constitutive elements of exclusion. The present contribution focuses on the Rohingya’s “reactions” to the structural aspects, excluding them because they do not belong to the local community (Schenk, 2021). Social exclusion appears as a “non-linear continuum” in which inclusion is not the opposite but rather the end of the continuum (Foblets et al., 2018). In addition, the multiplication of boundary-drawings practices (and the “biopolitics multiple”) constitutes an accurate concept for grasping the exclusionary mechanisms I observed during fieldwork with Rohingya women.

Exclusion means being kept apart, either physically or emotionally, through rejection (e.g., discrimination). Some psychology scholars view forced migration as inherently linked to the status of exclusion because refugees experience separation from their country of origin (Marinucci &

Riva, 2021). Other scholars argue that migrants feel out of place due to everyday boundary-drawing and “interior frontiers” in the host country (Lems, 2020). The notion of exclusion may apply from the outset to some refugees due to their experiences of displacement; however, the multiplication of boundary-drawing practices, transferred into the social domain of the everyday life of refugees, acquires prominence as the constitutive aspect of the experience of exclusion (Lems, 2020, p. 116).

Having defined refugee camps as exceptional zones of rights and power, anthropologists have demonstrated that humanitarian aid and exclusionary mechanisms in the camps are conditional to refugees’ segregation (Agier, 2011, p. 39). Hence, the representation that refugees will be provided with humanitarian services only if they are kept isolated. These resources are not always aligned with refugees’ necessities, and research has shown that humanitarian aid is rather “imposed” (Harrell-Bond, 1986). Besides, it is important not to dismiss the impact of organisations, affecting decision-making processes, internal structures, hierarchies, and inequalities among migrants (Lang et al., 2021, p. 8, 11). Within the “Meso-level”, it is important to consider the notion of “*subtractive biopolitics*” debilitating migrant bodies, which are kept on the move in the camp. Within biopolitics, refugees are thus *hyper-mobile* to access certain services available only at some distribution points and a delimited time (Aradau & Tazzioli, 2020, p. 214).

Camp rules are constantly changing, and this is also described as the prevention of “stabilisation” in refugees’ lives. In this context, refugees move continuously, and therefore, the notion of “inclusive disjunction” explains the heterogeneity and opacity that obstruct migrants’ lives and mobility in the camps (Aradau & Tazzioli, 2020, p. 219, 220). Hence, the humanitarian response acquires the “Janus double-face” of the provider and the controller (Verdirame & Harrell-Bond, 2005). Aradau and Tazzioli (2020) overcome the binary opposition in migration studies between agency and victimhood because the concept they propose of “*biopolitics multiple*” as establishing various forms of control allows for the activation of horizontal resources that are also multiple. In this regard, the idea of “accidental community” or “accidental community of memory” identifies the ties that emerge due to the “accidental sharing of memory and transitory experience” in the camps (Malkki, 1997, p. 91). In

other words, generations of people who are not related in familiar terms but share the experience of persecution or of life in a refugee camp, carry traces of a shared history, producing accidental communities of memory (Malkki, 1997, p. 92).

3 Social Exclusion and Hyper-mobility in the Informal Settlement Camp

A woman in her forties, living in a camp in the Kutupalong area, approaches me. Her name is Rubina, and she comes from the Rakhine State in Myanmar.³ She seems curious and extroverted. I can see it in her eyes, the only visible part of her body since she wears a burqa. She came to Bangladesh before the significant influx of 2017. As a result, she had to manage her life with her family in a village without being supported as a “real refugee”. At the time, there was no humanitarian assistance for Rohingya people living outside the two registered camps. Today, Rubina lives in a new refugee camp. I do not fully understand the dynamics she describes for various reasons; their stay in Bangladesh has a long history and has been impacted by various policies. Ultimately, this meeting takes place at a very early stage of my fieldwork.

Between 2010 and 2012, Rubina and her family settled with other people in makeshift settlements. The Rohingya inhabiting these informal settlements next to the two old camps were denied access to humanitarian services and, along with others living outside the camps, were referred to as “unregistered refugees” (Uddin, 2012, p. 3, 11). In other words, they were not treated as “real refugees”, as Rubina suggested, since their presence was not recognised until 2017. Unlike the Rohingya in the two “registered camps”, also called “old camps” due to their establishment in 1991, those in the informal settlements had to manage resources on their own. They constructed their shelters in the hope that the refugees of the old camps would have supported them in one way or another.⁴ This did not

³ Names of research participants have been changed to preserve their anonymity.

⁴ “Registered camps” and “old camps” were terms used interchangeably by Rohingya, the local people and the humanitarian actors in this fieldwork.

happen, and Rubina's daughter, Nasrin, recalled those years with a sense of exhaustion and disgust. She said: "When we came here, this was a jungle. So, we made a house here with my brother and my five sisters. [...] When we moved here, at the beginning, I didn't like the environment at all. It was hot, the house was surrounded by the forest, and we made this house with our own money, [although] at the time we didn't have much money. Our condition was awful: we were drying up in the sun and getting drenched in the rain. There was no fan; the house was small..."

Rubina: There was dirt everywhere!

Nasrin: We built a small house within the jungle, and everybody stayed around us like flies. [...] We cried every day because we didn't like it here. We used to go to the lower part of the *mura* to collect wood and leaves to put on the roof so that the house could be a bit cooler.⁵ We felt hot in the house and suffered from the lack of water since there was no tube well, no toilets...the situation started to become comfortable 3 or 4 years [ago]. Before, it was hard. We didn't get any food rations; we had to depend on our income, and nobody gave us a single piece of tarpaulin.⁶ Nobody gave us a single *puya*.⁷

Rubina: I had to do so much work to take care of these children.

Nasrin: We lived on our own all these years until 2017, when new people came, and the food rations started being donated not only to the 'old people' but to everybody. Before, for 8 or 9 years, we didn't receive any food rations. Our life was hard.

Valentina: How did you end up settling here?

Rubina: We came here because of our relatives who came here as well. Nasrin's father once said:⁸ 'Everybody has moved there. There is a rumour that there might be some facilities for us'. So, as soon as he said this, we moved here. When we arrived, I realised that there was nothing for us. (R., personal communication, 2022)

⁵The word *mura* means forest.

⁶Tarpaulin is a common material provided by the NGOs for refugees to construct their shelters.

⁷The word *puya* indicates 250 gr of rice.

⁸Among Rohingya, instead of using directly the word "husband", other circumlocutions were used as a form of respect, such as "the father of my children" or "your uncle".

For almost a decade, Rubina and other Rohingya faced the challenges of settling in the wild environment around the old camps. Because of the weather and the lack of infrastructure, Nasrin described this dense jungle as a place where they could not rest, even in the house they built.⁹ She said that as soon as they could collect some resources, other people were around them “like flies”. The daily work was hard for Rubina because it required her to go to the deep forest (the *mura*) to collect wood to build the house or to sell it in the market and buy food. These stories resonated as very old vicissitudes, especially because in the camps, very few trees were still planted: since the creation of new camps, the area of Kutupalong has been deforested. Finally, in 2017, Rohingya were all included in the humanitarian response and started receiving food rations monthly, free medical health care, access to water and many other services and infrastructure. While Rohingya were not formally recognised as “refugees” like those in the two registered camps, they were addressed with a new term – “forcibly displaced Myanmar nationals” (FDMN).¹⁰ Nevertheless, thanks to being included in the humanitarian response, many Rohingya could earn a living in this new context of the camps. This was the case for Rubina, whose outgoing personality and experience led her to become a community health worker (CHW) at the camps’ primary health centre.

As a community health worker, Rubina was responsible for informing Rohingya about the medical services available in the camp and went from house to house to promote health programmes, like the COVID-19 vaccination campaign. Thus, not only did she know several people in her camp, but she also earned a stipend.¹¹ Daily, she used to walk all over the

⁹While from October to February there are average low-temperatures of 20–30°, during the months of March, April and May the average temperatures rise to 35–38°. These weather conditions are challenging in the camps, where the area has been massively deforested to make place for more shelters. During the rainy season (from June to September) the mortality rate in Rohingya camps increases due to floods and landslides.

¹⁰In the articulated legal debate around refugees in Asia, Rohingya are usually defined as stateless. As many other stateless people in the world, Rohingya occupy one of the most challenging positions within the displaced populations. Most of them have no valid documents, such as birth certificates, and often remain *de facto* stateless without being neither recognised nor granted basic rights.

¹¹The monthly stipend for this kind of work is about 7000 Bangladeshi taka, which corresponds to 55 € (RRRC and ISCG 2018, “Guidance on Rohingya Volunteer Incentive Rates”, available at: <https://rohingyaresponse.org/wp-content/uploads/2023/05/CfW-and-Volunteer-Incentive-Rates-2018.pdf>, lastly accessed on the 30th of June 2024).

camp for hours, and when walking with her, I noticed that each camp had a specific structure of 5 to 7 blocks for administrative reasons. Rubina was responsible for one block. In her camp, blocks were just signposted by a pink board designed by BRAC, a Bangladeshi development organisation that operated in the informal settlement camp through a United Nations High Commissioner for Refugees (UNHCR) mandate.^{12,13} In 2017, BRAC expanded its humanitarian work in this region, employed 1300 staff and, among other NGOs, trained 800 Rohingya volunteers (Lewis, 2019, p. 1891). People like Rubina acquired the role of “beneficiaries” for the first time in 2017, but many among them have also benefitted from the fact of being employed as “volunteers” in the humanitarian response – as they were addressed by humanitarian actors Rohingya could not have been hired otherwise due to their legal status in the country. Despite these advantages, they have experienced social exclusion in terms of more restricted mobility. They were used to moving freely in the area until 2017, and soon, it became evident that external boundaries and demarcations within the camps could affect their mobility.

The separation between the informal settlement camp and an adjacent camp impacted the everyday lives of refugees in terms of facilities and services provided by humanitarian agencies. For example, the camp hospital managed by the NGO Save the Children in the adjacent camp shared its border with many houses in the informal settlement camp. For those families from the informal settlement camp living next to the adjacent camp, using the Save the Children health facility was generally more convenient. However, Rubina’s health facility had a different perspective on the matter and began pressuring her and other community health workers whenever they were unable to accompany pregnant women to their health facility. The NGOs’ main interest was to register as many patients as possible to receive donations at the cost of Rohingya’s hyper-mobility. Rohingya’s mobility was primarily affected by the encampment policy and was restricted to the outside; still, this example showed that people’s inner mobility in the camps could also be a means of control.

¹² Initially founded as the Bangladesh Rehabilitation Assistance Committee and then named as the Bangladesh Rural Advancement Committee, the organisation is today known as BRAC.

¹³ Each camp was managed by a different NGO under either the United Nations High Commissioner for Refugees (UNHCR) or International Organisation of Migration’s (IOM) mandate.

The encampment policy refers to the separation of refugees from the local people and the limitation of mobility since refugees are obliged to stay in the camps. Concerning encampment measures, people in the informal settlement camp started enacting strategies to cope with their lives of social exclusion.

As our friendship grows, Rubina invites me to a particular event. Her two granddaughters will have their ears and nose pierced. They are Rubina's eldest daughter's daughters and live in a village outside the camps. For the occasion, Rubina wears a beautiful violet *sari*, one of the most common clothes in Bangladesh. She can change her dress code so easily, I think. As soon as we discuss her style, she says this is a necessity because, formally, Rohingya are not allowed to walk outside the camps. Whenever she needs to go outside the camp area, she has to wear specific clothes and slightly adjust her language or manner of speaking to cross the checkpoint.

Two of Rubina's younger sisters, their families, and her older daughter live in a village approximately 50 kilometres distant from the camp. Rubina used to visit the village regularly with her daughter, Nasrin, especially for important celebrations, like the piercing ceremony of her 13- and 11-year-old granddaughters. Unfortunately, I am not as familiar with the region as they are, and it takes me some hours to join them in the village. For this reason, I can only listen to the stories and watch the video of the celebration, in which Rubina first pierced the ears and noses of her eldest granddaughter. The granddaughter was then carried by her mother's aunt's son to the nearest banana tree in the neighbours' backyard; it is believed that, by touching the tree, pain is reduced.¹⁴ Then, it was the turn of the younger granddaughter, who also had her nose and ears pierced. At this time, Rubina's son brought her to the tree. Neighbours and relatives visited the house for the whole day, where they were offered food and drinks. I get to watch these videos while sitting in the second room of Rubina's daughter's place, just after the entrance room. I am with Tonmoy, my research assistant, and we are offered some watermelon and mangos to eat there. We sit around a plastic table with Nasrin and her husband. Later, Rubina joins us, wearing that beautiful violet *sari*. I am astonished to observe how easily Rubina and Nasrin can change their

¹⁴ The banana tree is also central in other rites of passage, such as marriage celebrations.

dress code! While sitting together, Nasrin explains that her aunts (Rubina's sisters) finally received ID cards. All of Rubina's sisters live in this village and are married to Bangladeshi husbands, except for another sister still living in Myanmar. Later, we take a walk together to a piece of land where Rubina's father planted three large mango and jackfruit trees when Nasrin was born 25 years ago. Rubina married here, where her father used to own various properties. It is surprising to me to see Rubina interacting with villagers. She greets and exchanges small talk with many people who she meets on the path. These are probably not Rohingya, but they are aware of her history and her life in the camp, I think. Many questions arise about Rubina and her sisters on this occasion: whether it is common or not for Rohingya in Bangladesh to own an ID card. They all seem to be respected in the village; they have lived in Bangladesh for generations, and the country will probably never be able to track them. "That's why the government is so concerned about the mobility of Rohingyas", adds my research assistant.

Days later, Rubina explained to me that changing her dress code was a necessity because, formally, Rohingya are not allowed to walk outside camps, and in the village, she needs to keep some secrets. To cross the check-post, she could have even worn a one-piece burqa instead of the two-piece burqa commonly worn among Rohingya. Local Bangladeshi women frequently use the one-piece burqa. However, Rubina preferred to wear a sari because this is what local women wear for festivities and other occasions. This woven fabric arranged over the body as a robe protected Rubina and her secret while crossing the check-post. She also changes her speaking whenever she needs to go outside the camp area. This other strategy will be explored more in-depth through the case of the old camp.

4 Heterogeneous Survival Strategies in the Old Camp

While chatting and having tea, one of Trisna's granddaughters sits next to us, doing her homework. Our conversation changes topic once I realise her granddaughter is writing in Bangladeshi. Trisna notices my facial expression of surprise and anticipates my question. Her granddaughter is

still attending school outside the camp. She is one of the few among her peers who continue studying in the family, although this has not been formally permitted since 2018. However, she has faced many difficulties. The greatest challenge came when the school administration asked her to show her home, as they suspected she lived in the camp. Luckily, a school friend covered for her by saying she was her cousin, and they went home to have the school staff talk to the friend's mother. Since that moment, Trisna's granddaughter pretends to live somewhere else so that she can maintain school attendance. Her mother regularly visits the friend's mother to get school updates.

Despite all the challenges and setbacks, refugees in the old camp were able to go outside to study and work until 2017, and they established solid social ties with local people. They took shelter in Bangladesh in 1991 when 200,000 Rohingya fled Myanmar at first. The majority were later forced by the Government of Bangladesh and the United Nations High Commissioner for Refugees (UNHCR) to return to Myanmar, even though they were not secure there (Crisp, 2018; Leider, 2020). An unreported number of people migrated again to Bangladesh and settled in villages until 2010 when 50,000 Rohingya moved to the informal settlements (Guhathakurta et al., 2016), and 20,000 Rohingya remained in the two registered camps.

Time allowed Rohingya from the old camps to share many moments with local communities and, like Rohingya of the informal settlement camp, enriched their knowledge about life in Bangladesh as well. This intersected with the fact that Rohingya already shared similarities with villagers in terms of language. As part of the same borderland, the Rohingya language is similar to the local language, Chittagonian. For instance, people who are permanent residents in Chittagong can speak the local language and are known as *Chittainga*, who consider all other residents of Bangladesh *Boingas*. Of the similarities in language, cultural traits, common history, and communication through business, some Rohingya feel closer to *Chittaingas* than to *Boingas* (Grillo & Chowdhury, 2023). Moreover, some Rohingya consciously use certain expressions that, when observed from the outside, allow them to be perceived as local people. For example, the first personal pronoun, "I", in Rohingya has two

forms: “*ay*” and “*moy*”. In the local dialect of Chittagong, only “*ay*” is used. Therefore, when crossing the check-post, many Rohingya strategically addressed themselves with the pronoun “*ay*” instead of “*moy*” to blend into the local population.

From the perspective of the Government of Bangladesh, the knowledge of the Bangladeshi language in its official form learned in schools (i.e., *sadhu bhasha*), is an important instrument therefore to differentiate Rohingya from *Chittaingia*. For this reason, especially given the similarity between Rohingya and the local language of Chittagong, another level of social exclusion was experienced by Rohingya in 2018, when the Government banned all Rohingya from attending public schools in the country. The Prime Minister first raised concerns about Rohingya children attending Bangladeshi schools, and some months later, the Refugee Relief and Repatriation Commissioner (RRRC)¹⁵ warned the directors of some secondary schools that enrolling Rohingya in schools was an act by “dishonest public representatives”.¹⁶ This was part of a policy to prevent refugees from intermingling with Bangladeshis. Besides, the authorities restricted the education programmes provided to Rohingya by NGOs inside the refugee camps and closed thousands of home-based schools in 2021.¹⁷ School buildings have been prohibited in the camps; however, NGOs could still build learning centres, which have been closed since the March 2020 COVID-19 response.¹⁸ During fieldwork, the learning centres were opened again, but with a restricted programme since, in most cases, there were only two classes, and education stopped at the age of seven for the children in the camps. For older children, therefore, the only courses available were from an informal network of Rohingya teachers, who were not allowed to teach Bengali, as knowing the idiom would foster life in Bangladesh and contradict the return policy.¹⁹ Most of these

¹⁵ The Refugee Relief and Repatriation Commissioner is the governmental office that manages the refugee camps (ISCG, 2023).

¹⁶ Human Rights Watch (2019).

¹⁷ Human Rights Watch (2021).

¹⁸ The Diplomat (2021).

¹⁹ This was reflected in the heated debate between the NGOs and the government about whether to adopt the Bangladeshi or Myanmar curriculum in the schools of the camps (The Diplomat, 2021).

teachers from the informal network had to introduce a minimum school fee to cover the basic expenses, excluding the families that could not afford this service. Trisna's granddaughter, like other Rohingya children in the old camp, was still able to attend schools outside the camp, and this was achievable thanks to the role played by social ties in this region. Nevertheless, as I continued my research in the camp and talked to its inhabitants, I understood that social ties could sometimes be damaging for Rohingya and limit their mobility within the camp.

The encounter with the "camp-in-charge person" was a remarkable moment.²⁰ From the beginning, the camp-in-charge person made it clear that my mobility was restricted due to safety concerns. More so than in other camps, my sojourns in the old camp were severely limited. For instance, I never visited some blocks because they were considered unsafe. Most humanitarian workers were nationals in this camp, which was considered dangerous for foreigners. The unsafety in this camp appeared to me rather as an excuse made up for a foreign researcher because the subject of forced migration was, in general, a sensitive topic (Harrell-Bond & Voutira, 2007, p. 285). As I proceeded with informal talks and interviews in the old camp, many women told me about the threats they had received from deviant groups. The character of unsafety acquired another dimension.

When I enter Trisna's, three women are sitting in the house. An older woman, Trisna's husband's sister, is visiting her relatives from an adjacent camp, Trisna and her daughter. Trisna starts telling me about an accident that happened one year before when some people kidnapped one of her younger sons and brought him to the jungle. He was rescued by the police, but 11 days later, these "bad people" came directly to their home. Trisna closed the entrance door to protect the rest of the family, and her daughter's husband stayed outside. When his father-in-law arrived, Trisna's son-in-law hugged him to shield him with his own body. The son-in-law was shot in his arm, and Trisna's husband in his stomach. Trisna starts crying, and her daughter brings the printed pictures of these wounds. Her family was threatened again because these people wanted money from them. Trisna's sister-in-law adds that she is scared to walk in the old camp; the adjacent

²⁰ The camp-in-charge person is the administrative representative of the Government, manages normally one camp and has the last word on camp decisions.

camp where she lives is safer. She whispers: “If people on the street see you wearing gold, they will cut your throat to take that”.

Due to the high criminality rate, the mobility in the old camp is compromised for many refugees, but Rohingya’s mobility depends on other dynamics as well. Since 2017, people’s mobility outside all 33 camps (including the old ones) has also been limited. Trisna’s son explained this: “Here, I cannot go outside the camp. It is like a jail. [...] You Bengali people can move whenever you want; for example, you can move from Chittagong to Cox’s Bazar, but we cannot. We were born here; we are Bengali, but Bengali don’t accept us as Bengali.”²¹ [...] The army stops cars to check for ID cards. If you can show them the ID card, then they will let you go, but if you can’t, then they send you to the camp. If anyone is sick and needs to go to Cox’s Bazar for additional care services, police do not even allow them to leave!” (T., personal communication, 2022) The camp-in-charge person reiterated the same position of the officers during a monthly meeting with NGO representatives in the old camp. He underlined the aim of improving services in the camp so that refugees did not need to leave the camp area. People from the old camp can only go to the next village to do some courses or for jobs available in the black market because, formally, they are not allowed to work. If the police find Rohingya breaking the rule that in the old camp forbids exit after sunset, in the best scenario, policemen will beat them and send them back to the camp.

Mobility restrictions have been implemented together with severe controls in the field of employment, and this contributed to enhancing the “cycle of criminality”. Officially keeping refugees away from labour has involved them in the black market and other illicit forms of income. While working informally could also be identified as a survival strategy - especially in the old camp where volunteer positions (like the one of Rubina who lives in the informal settlement camp) are less common - being involved in criminal activities turned against other Rohingya and aggravated their condition of social exclusion. Many families whose

²¹ Trisna’s son was born in Bangladesh. So, his sense of belonging to Bangladesh is mainly due to the fact that he was born and has been living his whole life in the country. This opinion should not be interpreted as the one of all Rohingya living in the old camp. What Trisna’s son said may represent what the youth population born and grown there in the camp thought, whereas this is not the same for the older generation who directly experienced the persecutions in Myanmar.

teenage or young male members refused to collaborate with these deviant groups active in the camp were not protected. These families have been threatened multiple times but could not denounce such episodes for fear of retaliation. These deviant groups were so well connected with the local authorities that, from the talks I had with Trisna and other women, menaces and the fear to denounce were concrete. Rohingya in this region have experienced delinquency in a diffused way, and this was connected to the dynamics of social ties with local people but also to their structural exclusion from the labour market.²² While the protracted displacement of the old Rohingya often turned out to be a resource since many of them were able to navigate the reality of Bangladeshi villages much better than the new refugees of the nearby camps (through language, for example), it also led to collaborations between deviant groups, mainly composed by Rohingya youngsters, local people, and some authorities.²³

5 Isolation Within the “Accidental Community” in the New Camp

Habib, the camp management volunteer, is in his twenties and, in the past five years, learned the Bangladeshi language on his own. Rohingya are employed as “volunteers” in different domains, and site management is one of these.²⁴ Habib describes the difficulties of camp life in terms of lacking mobility since, for example, he is not even allowed to leave the camp if he wants to buy something for his grandmother from the market in the adjacent village. During the Monsoon season, the profile of the Burmese hills, which one can see from the camp throughout the year, disappears. As Habib explains to me, this landscape, together with small gardens, constitutes a relief for some refugees who are in permanent

²² The term “delinquency” captures both the dimensions of an action which is legally proscribed and committed generally by minors, vulnerable or neglected people (McLaughlin & Muncie, 2019).

²³ During an official meeting between the camp in charge and NGOs, the former lamented that children smuggled frequently drugs in the camp.

²⁴ “Volunteers are helping with water and sanitation, temporary shelter construction, emergency preparedness and response, reforestation, teaching classes in the Myanmar Curriculum, and assisting Rohingya children, adolescents, persons with disabilities, and women-at-risk” (ISCG, 2023).

encampment. Limited space for cultivation is available to some Rohingya in their backyard. Still, the camp is separated into two parts so that less land is designated for them: each block corresponds to one hill. The land between the hills is excluded from the camp zone. Hence, Rohingya are not only restricted in their mobility outside the camp area but also constricted in terms of spaces accessible in the camp life. The part of the camp closest to the town is called “town site”, and the other is named after an Arab country, here called “Arab country site”.

The cause of Rohingya has reached the Muslim community worldwide, and an Arab country donated a considerable amount of money and facilities - e.g., out of three hospitals, one was indeed the Arab country hospital. Hence, the name of the site followed that of the Arab country.²⁵ From the town site, one can reach the Arab country site either by walking 10 minutes through the blocks or by vehicle taking the external road. Some people can go out of the camp just for a short distance.

The new camp was located close to a town where the Government attempted to construct another refugee camp after 2017 but did not succeed after the local people's opposition. Hence, in the area, there was only the new camp that highlighted the essence of exclusion in terms of space. While in the informal settlement camp and the old camp, Rohingya experienced an official limitation of their mobility but were able to activate survival strategies to go outside the camp; the Rohingya living in this new camp appeared to be confined in the space of the camp. They were allowed to go out only for officially accepted reasons (e.g., hospital or court visits). Otherwise, this camp was isolated since it did not share any border with other camps. For instance, Rohingya were not able to visit markets in other camps. At the beginning of my fieldwork, I thought refugees in this camp to be naïve compared to the old refugees because they were new to the country. As in the case of Habib, people in the new camp fled Myanmar in 2017. The recent episodes of violence and persecution in the Rakhine State soon emerged as important factors influencing the behaviour of people in the new camp.

²⁵ There is a significant presence of migrant workers both Bangladeshis and Rohingya in the Arab countries of the Persian Gulf. Some of these countries support financially the Rohingya Response in Bangladesh.

Habib recalls the last years of his life in Myanmar and highlights that even there, their mobility was highly restricted. He explained to me that 135 ethnic groups were recognised in his country, but Rohingya were excluded from citizenship and, for this reason, were not free to move.²⁶ Besides, he explains that many people went to Bangladesh earlier because they could not leave the Rakhine State to be cured elsewhere in Myanmar. Habib invited my research assistant Tonmoy and me to his place to meet his grandmother, who addresses similar topics of discussion with us. Her name is Mohima, she is 70 years old and comes from Maungdaw *thana*.²⁷ She used to have three daughters and one son; the latter died due to breathing issues, whereas two daughters passed away due to diarrheal problems. Her husband died due to breathing issues, but he was at least brought to Bangladesh for treatment. In the camp, she lives with five other family members: her stepson, his wife, and children. Her husband had a first wife who was also living with her. In Islam, second marriage is allowed as long as wives are treated equally, and it is a common practice in the camps. These relatives do not treat Mohima as part of the family, but Habib, her daughter's son, visits her from time to time. She tells us that she misses everything from Burma, such as her house, her land, the food and the cooking! After asking her what she misses the most, she replies: "If I tell you, do you send me back?" and starts laughing.

Habib explains that they receive food rations monthly, including 13 kg of rice and one bottle of oil per person, potatoes, vegetables, and sometimes fish. They only get frozen fish instead of fresh ones. He adds, "We can't get any seasonal food here. If in Burma, we want a mango, guava or lemon, then we go and pick it from the tree. Here you need to go to the market. Here it is like that: Bangladesh is a congested country, whereas Myanmar is kind of 'open'. There, you can do farming and cultivation. It is a big country with a lot of land. If you don't leave the *thana*, you can walk without restrictions". Besides, the water is not good in the camp, and

²⁶ Habib refers to when in 1988 the State Law and Order Restoration Council, i.e., SLORC, defined the "135 national races of Myanmar" as part of the "Myanmarization" nationalism and excluded Rohingya from the country (Gravers, 2007, p. 4).

²⁷ The *thana* system originates from the colonial rule to distinguish sub-district administration, and was substituted by the upazila sub-districts in Bangladesh, but was maintained in Myanmar. Maungdaw is in north Rakhine State, close to the international border with Bangladesh.

drinking it causes skin allergies, but they still have to drink it. Moreover, many diseases affect Rohingya in the camp, especially gastric problems.

In the new camp, Rohingya seemed to accept their condition of restricted mobility and generally respected the rule of not leaving the camp. This was influenced by the isolation of the camp, as well as by the distribution of humanitarian aid. As already mentioned, humanitarian aid is conditional to refugees' segregation in camps, and Rohingya are aware of this condition. For example, Mohima laughed at my questions and made fun of a dynamic that is quite frequent in the camp. The fact of presenting herself as a victim to then receive something in return from NGOs. Thus, she asked: "If I tell you [what I miss the most], do you send me back?" However, the recent experiences of persecution in their country of origin, as well as the limited mobility in Myanmar, where they were not allowed to go outside of their sub-district (i.e., the *thana*), make this eventuality of returning very remote. Besides, this condition of perpetual immobility in Myanmar contributed to their present attitude of acceptance of their immobility in this new camp. Nevertheless, this did not mean they were passively agreeing with the restrictions in Myanmar or the camp. Many Rohingya died as a consequence of the denial of health care services in other parts of the country, whilst many others decided to migrate to Bangladesh to counterbalance this situation. Mobility is one lens to look at the exclusion affecting Rohingya and their ways of reacting to this condition in Bangladesh.

Food was another level to investigate exclusion among Rohingya in the camps. In Mohima's words, Myanmar was acclaimed in terms of being "an open" country where she could cultivate her land and pick fruits from the trees, whereas Bangladesh was identified as "close" because food was only distributed by NGOs or eventually bought at the market. In the camps, while access to food depended on Rohingya's mobility and ability to reach certain places, another prominent aspect is the food distribution by NGOs. Heated debates began in March and June 2023. Namely, one year after my fieldwork, when the World Food Programme (WFP) reduced the monthly food voucher from US\$ 12 per person to US\$ 10 and then US\$ 8.²⁸ The camp population was already malnourished

²⁸ Recently, it has been announced that food rations will be raised again to US\$ 10 (WFP, 2023).

during my fieldwork, and this was, for instance, the case of many pregnant women and new mothers who developed problems while lactating their newborns. Nutrition-specific services for lactating women were provided in the new camp, but many prefer to be assisted by their community and “*ful dhoroni*” (i.e., child puller). In this way, they avoided the hostile behaviour of midwives and doctors working in the hospitals opened within the humanitarian response in the camp. They rather preferred to rely upon the members of the Rohingya accidental community of the new camp.

6 Conclusions

As shown in this contribution, refugees’ mobility inside and outside camps is a lens to explore social exclusion and survival strategies among Rohingya. Despite refugees not being allowed to leave the camp area, they benefit from the humanitarian response in that some people, like Rubina, are employed as volunteers and earn a regular salary. Can we look at the mobility of some volunteers that enhanced across the camps as an example of hyper-mobility? Rohingya who have lived for years in informal settlements tend to make the most out of local knowledge to act as locals. They appreciate their mobility as a resource to go outside the camps. In this way, they can cultivate family ties, like the ones with relatives who settled in the villages. Leaving the camps allows many people to find an occupation in the informal labour market, but mobility is revealed to be an essential resource for Rohingya also across camps.

In the old camp, instead, the collaboration between Rohingya and local people showed from the outset the supportive face of Bangladeshi families. As illustrated through the example of the old camp, thanks to social ties with local communities, some students keep moving secretly and attend schools. Nevertheless, the social ties between local people and deviant groups have contributed to criminal activities, leading to the immobility of many families in the camp. Thus, mobility acquires its characteristic of “inclusive disjunction” obstructing in various ways Rohingya’s lives.

Whilst the conditions in which refugees live also affect their survival strategies, these also vary according to when Rohingya fled Myanmar and where they live in Bangladesh. Rohingya faced for years the challenges of life in the makeshift settlements. When the settlements were recognised as camps in an area where many NGOs were active, Rohingya twisted the previous years spent in Bangladesh as a kind of resource. They were able to hide their identity if they wanted to go outside the camp and made the most out of the humanitarian services available to them. Rohingya in the old camp used their local knowledge as a resource to adjust their way of speaking and, in the case of Trisna's granddaughter, attended schools. Social ties were fundamental for them to hide their identity for specific reasons, but they also turned out to be detrimental. They reinforced the criminal activities in the region and endangered the lives of entire families in the camp. Overall, these examples questioned the value of the social ties between Rohingya and local people, as well as the contradictory function of the humanitarian actors.

The encampment policy was successfully implemented in the new camp for different reasons. The people living in this camp, isolated from others, have been recently affected by the violence in Myanmar. Furthermore, they experienced a substantial mobility limitation in the Rakhine State. Therefore, they were particularly affected by the movement restrictions and violence in Myanmar. Sometimes, they seemed resigned to their encampment condition in the refugee camps. However, they relied upon the social ties within the camp of either relatives or neighbours. They rather trusted "strangers" with whom they shared the transitory circumstances of everyday life because they were part of the community of the new camp.

Rubina, Trisna, and Mohima all had different experiences of forced displacement in Myanmar and social exclusion in Bangladesh. Independently from the fact of having fled Myanmar once or multiple times, they tackled the various practices of social exclusion in different ways by transforming mobility, local ties, and humanitarian aid into resources, aware that these could have turned against them as well. They navigated their everyday lives by drawing from their knowledge of the local culture, benefiting from social ties, the humanitarian response services, and their acquaintances in the context of refugee camps.

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CHAPTER SIX Rohingya Women's Perspectives on the Medicalisation of Births in the Informal Settlement Camp

1. Introduction

I am part of a small group of women who assist a birth in the informal settlement camp. I am holding the back of Latifa, the pregnant woman, and a community health worker on her side, while the birth attendant Naslima is also on the floor, repeating *bismillah*¹³⁸ and holy words next to her. The initial settings of this birth are similar to the ones that usually characterise homebirths, although we are in the delivery room of the hospital. Latifa, Naslima and I got there from the labour room where pregnant women usually stay before or after their delivery. A couple of minutes later the community health worker joins us. Initially, I observe the community health worker and the birth attendant supporting Latifa. The two Rohingya women have different roles and tasks in the health facility.

Shortly afterwards, a Bangladeshi midwife enters the room and asks the pregnant woman to move to the bed. The Rohingya birth attendant, Naslima, who was previously on the floor, is now again on the pregnant woman's side. The Bangladeshi midwife is in front of her to help her push out the baby and the placenta, which, as she says, will not be easily expelled because the baby is premature in the pregnancy's eighth month. The birth attendant holds a veil to ensure that the woman's genitalia are not visible and Latifa feels more comfortable throughout the delivery. The baby is born, and the placenta is delivered.

I am standing at Latifa's side and feel I am about to faint as soon as I see Roxana (the Bangladeshi supervisor of the midwives) cleaning the remains of the expelled placenta in her birth canal by wearing a long plastic glove and using her hand. This practice is done to prevent infections. I breathe deeply and feel better, although the midwife continues with the painful practice, and the pregnant woman is still suffering as is evident by her unusual screaming. In fact, Rohingya women avoid screaming during deliveries, but Latifa is not at ease with this practice.

My nausea does not originate from the view of the placenta *per se*; it rather comes from the poor behaviour towards Latifa and the hierarchies present in the room. Rohingya women are not treated well by midwives because they are perceived as "uneducated and with a lot of children", as I repeatedly heard in this health facility.¹³⁹ This attitude of

¹³⁸ *Bismillāh* literally means "in the name of Allah".

¹³⁹ This hospital was managed by the Research, Training and Management (RTM) International organisation.

superiority is present in other health facilities as well, but I soon realise that the Rohingyas are not the only targets of this behaviour, as I can observe it also in the interactions between the Bangladeshi doctor and the midwife. In Bangladesh, midwifery occupies a very low position in the hierarchy of hospitals, and many midwives express their profound frustration while interacting with Rohingyas, but they are also targets of this attitude. This behaviour becomes tangible in the way the doctor tells the midwife to clean the remains of the placenta or in the midwife's attitude when asking Naslima to wash the blood away from the floor. However, there is no verbal violence between the Rohingya birth attendant, Naslima, and the pregnant woman, Latifa.

In addition to the exclusion that is exerted towards all Rohingyas, many other dynamics affect mainly Rohingya women who experience a gendered dimension of this social exclusion.¹⁴⁰ Many Rohingya women like birth attendants experience social exclusion in that their role and expertise are not acknowledged in the camps as the “authoritative knowledge” (Jordan, 1997) accepted within the medical discourse in the hospital is different from the one practised among Rohingyas. This form of social exclusion does not suddenly manifest to me during fieldwork and it takes some time before I can directly observe such dynamics. The more time I spend at the hospital, for instance, the clearer this form of social exclusion appears to me. Global policies and the humanitarian response has led to an ever-growing number of medicalised births in this camp. Generally, Rohingyas avoid health facilities because of how the medicalisation of birth plays out on the grounds of the camps. This chapter aims to outline how Rohingyas experience the medicalisation of births by considering different layers at play in the implementation of this rule while specifically looking at the informal settlement camp.

2. The Primary Health Centre in the Informal Settlement Camp

Tonmoy and I arrive at Kutupalong Bazar, where the road is crowded due to extreme traffic congestion. It is Sunday, the first day of the week. Maybe this is the reason for such traffic. After breakfast at a typical Bangladeshi restaurant in the market where female white people are not so common – in fact, I have been negotiating my presence there for some time - we walk to the camp area. Both Rohingya men and women are walking on the main road leading

¹⁴⁰ For example, the gendered dimension of exclusion involves also Rohingya *hijra* who are typically identified as male at birth, but later do not identify as either male or female, as they recognise in a unique gender identity (K. A. Uddin, 2025).

to Kutupalong camp, carrying large gas cylinders. Today is also the day of collection for various goods distributed in the camps. We arrive at the office of the camp-in-charge person for the informal settlement camp. There, we meet an individual who holds the official governmental position of “community mobilisation officer”. I am not aware of what his role exactly consists of, but I am pretty sure that he is much closer to the camp reality on the ground than the camp-in-charge officer. He explains to us that there are three health facilities in the camp: one is managed by the International Organisation of Migration (IOM), one by the Gonoshasthaya Kendra (GK), ¹⁴¹ and the third by Research, Training and Management International (RTMI). This description confuses us because we know only of two hospitals. In fact, we soon discover that the RTMI facility is actually within the GK hospital. He accompanies us outside to point the hospital to us.

We arrive at the GK\RTMI hospital for the first time and write our names and personal information in a register on a table at the entrance. I am unsure whether anyone will ever check this data, but I believe organisations want to have a general overview of what is happening. In front of the health centre, there is a vast waiting area outside with at least six benches. Upon entering the health facility, there is a smaller waiting area with four benches, followed by a long corridor. On the right and left, there are six to eight rooms for individual patient examinations. At the end of the corridor, the reproductive ward, the RTMI section, begins. On the right side are two small rooms: one for family planning methods and another for antenatal check-ups. In front of these rooms is a tiny waiting area with two benches. At the end of the corridor, a door leads to the other part of the reproductive ward. Another corridor, perpendicular to the main one, forms a large “T”. On the opposite side, there are two doors: the right door leads to the labour room, which contains four beds, while the left door leads to the delivery room. On the right, there is a room for medical personnel to rest and on the left there is the placenta pit.

We meet Rubina who works for the RTMI facility as a community health worker and she is excited about our visit at her work place. We first talk to two Bangladeshi midwives who explain to us that the RTMI provides reproductive health services, whereas the GK offers general medical services. They inform us about the services available and collaboration with Rohingya Community Health Workers (CHW) and Traditional Birth

¹⁴¹ GK stands for *Gonoshasthaya Kendra*, namely, the first health centre in Bangladesh after the country’s independence. Nowadays it is a public charitable trust that operates in the refugee camps. *Gono* means people, *shasthaya* health and *kendra* centre.

Attendants (TBA).¹⁴² Community health workers transport pregnant women to the hospital and assist them, while traditional birth attendants help with deliveries and also address communication issues, as both midwives come from the Division of Sylhet and do not understand the language. They also tell us that Rohingya women are generally not interested in ante-natal or post-natal services and they do not want to deliver in the hospital. Besides, when there are complications, it is challenging to refer her to a specialised health facility outside the camp because most of the time, Rohingyas do not want to go.

During our next visit to the hospital at the informal settlement camp, Tonmoy and I register at the entrance as usual before heading to the family planning office run by Ipas.¹⁴³ Ipas offers several family planning methods to Rohingyas: the pill, condoms, injectables (methods that provide contraception for three months), implants (which lasts for three to five years), and IUDs (the intrauterine device prevents pregnancy for 10 years). The staff recommends these methods to families with seven or eight children or to mothers who are older or have medical conditions, such as hypertension. They assist Rohingya women in “regulating their menstruation”, which stands for abortion and post-abortion care. Forced marriages and rape contribute to unwanted pregnancies, which were common in 2017 following the largest influx of Rohingyas. The medical personnel explain that Rohingyas believe that Allah grants them children, so they are reluctant to engage in family planning activities because they do not want to go against god’s plans. Rubina interrupts us so we can join her during her visits to pregnant women across the block as part of her duty.

3. The role of a Community Health Worker and her Family

We walk to the block, and Rubina moves so quickly through the narrow paths of the camp that I soon lose my sense of direction. We make an unexpected stop at a young man’s home, where celebrations are taking place for his son’s circumcision. Rubina explains to Tonmoy and me that births are usually not celebrated, but circumcision, marriages and funerals are. She tells us of a Rohingya man who died and his wife and children agreed to

¹⁴² As the doctor of this facility once clarified to me, the two *dhoroni* working in the hospital should now be officially addressed “community birth attendants”, although they are most of the time still called “traditional birth attendants”.

¹⁴³ Ipas was founded in 1973 in the U.S. with the aim of expanding access to legal abortion in various countries. The international NGO has collaborated with the government of Bangladesh since 2011 on “menstrual regulation” allowed in the first twelve weeks of pregnancy (see more at: www.ipas.org).

be resettled to the island of Bashan Char.¹⁴⁴ To pay for his funeral the man's mother has been supported by the whole community, as funerals have to take place. At the end of the visits, she will lead us to her.

Rubina first takes us to a shelter where a pregnant woman's parents live. However, nobody is there. So, we proceed to her place. Her name is Laila; she has two sons and she is expecting a baby in a couple of months, likely around *Eid al-Adha* (one of the main festivals in Islam). Rubina performs the checks required from the hospital. She advises Laila on what to eat, how to prepare the food, and inquires about how she feels. Rubina fills out a form for Laila's hospital file. She explains to us that post-natal care lasts 42 days after delivery and includes three to four check-ups. Laila has followed family planning methods to ensure appropriate age spacing between her children. Rubina reiterates the importance of family planning, and reminds her of hygiene practices for her and her children, of cleaning the house and of doing the dishes. She also reminds Laila to bring her children to the hospital for vaccinations.

Laila shares with us her story. She came to Bangladesh when she was young and has no memory of Burma. She is 25 years old and arrived with her family in Bangladesh 15 years ago. They initially lived outside the camps, but after her marriage she moved into the camp with her husband. Her parents also moved to the camp and lived nearby, while her siblings settled in other camps.

We thank Laila for her hospitality and leave to meet the next woman. While walking through the narrow paths of the block, many people around address Rubina as the community health worker of the block. We encounter a woman and her paralysed son on the path, whom we met in December 2021. They kindly greet us and ask Rubina about some medicines. An old man approaches Rubina as well, showing her that his ear is infected. They are interrupted by another neighbour who complains to Rubina that she did not receive enough pills at the hospital for his son, who has a fever. Rubina replies that next time she will tell the doctors to give her chickpeas instead of pills so she can get as much as she wants! Rubina starts laughing, and in the meantime, another neighbour, a pregnant lady with swollen ankles, slowly walks in our direction. She shows Rubina her ankles and then goes inside her house. She is the next woman we meet.

Her husband stands at the threshold, holding his daughter, who keeps staring at me as she is tremendously frightened by my appearance. The lady is in the ninth month of her

¹⁴⁴ Bhasan Char is an island in the Bay of Bengal, where the government of Bangladesh relocated nearly 27,000 Rohingyas (WFP, 2023a).

pregnancy. We enter their house and sit on the floor next to Rubina and the woman's husband. The pregnant woman goes to another room and does not sit with us. Rubina tells the husband not to follow the procedures as they did for the previous home births of their children. This time his wife will give birth in the hospital. They have three sons who were born at home, and Rubina sounds very resolute in her interaction with the husband. She writes her number on the wall behind her and says that if they need anything, they can just call her. The family is not convinced about the hospital birth because the journey to the RTMI facility is long and difficult from their block. The man wears a bracelet, called *tabis*, on the upper part of his arm. It is a sort of religious bracelet for protection, Tonmoy explains to me. Rubina continues to talk to him, and the more they talk, the more we understand the situation of this family. They mention that the pregnant woman has mental health issues. Finally, she comes to the room but barely enters, as she stands on the threshold and gives some documents to her husband. The documents report on her epilepsy. I think this is probably why they refer to her as *asor bisor*, which means she sees demons. This is probably the reason why she hides in the other room and never sits with us. In fact, Rubina only interacts with her husband.

A discussion outside the shelter takes place between a couple, whose screaming interrupts us. We can hear their quarrel about money. The husband involved in the discussion earns money that he does not share with his wife, and a female neighbour intervenes to defend the wife:

“You are the worst husband! How dare you carry your money unsafely in your trouser pockets? Your wife is the one who should have access to your money since she manages the household!”

Rubina goes outside, while we stay in the room. We start talking directly to the husband. He tells us that he comes from the same village of Mohib Ullah ¹⁴⁵ and his family of Islamic intellectuals. He tells us that Mohib Ullah was so great that he was able to arrange a marriage for each of his seven sisters. The husband mentions as well that his wife's elder brother was in prison in Malaysia. Mohib Ullah helped him to fill in a sort of application to rescue the brother-in-law in Malaysia. He says that Mohib Ullah might have left for Malaysia and returned within one day. We ask him how he met his wife since he tells us that he used

¹⁴⁵ Mohib Ullah was a Rohingya community leader who founded the “Arakan Rohingya Society for Peace and Human Rights”. The Arakan Rohingya Salvation Army (ARSA) killed him in 2021 in his office (M. Ali & Lopes, 2022), although many Rohingyas considered him to be a fundamental and prestigious Rohingya leader.

to live in another camp with his family. He tells us that she is his cousin, and they did not celebrate their marriage. Rubina, who has just entered, changes the topic of our discussion and reminds him that there might always be an ambulance to pick his wife in case they change their minds. We leave the house and walk to the last pregnant woman for today.

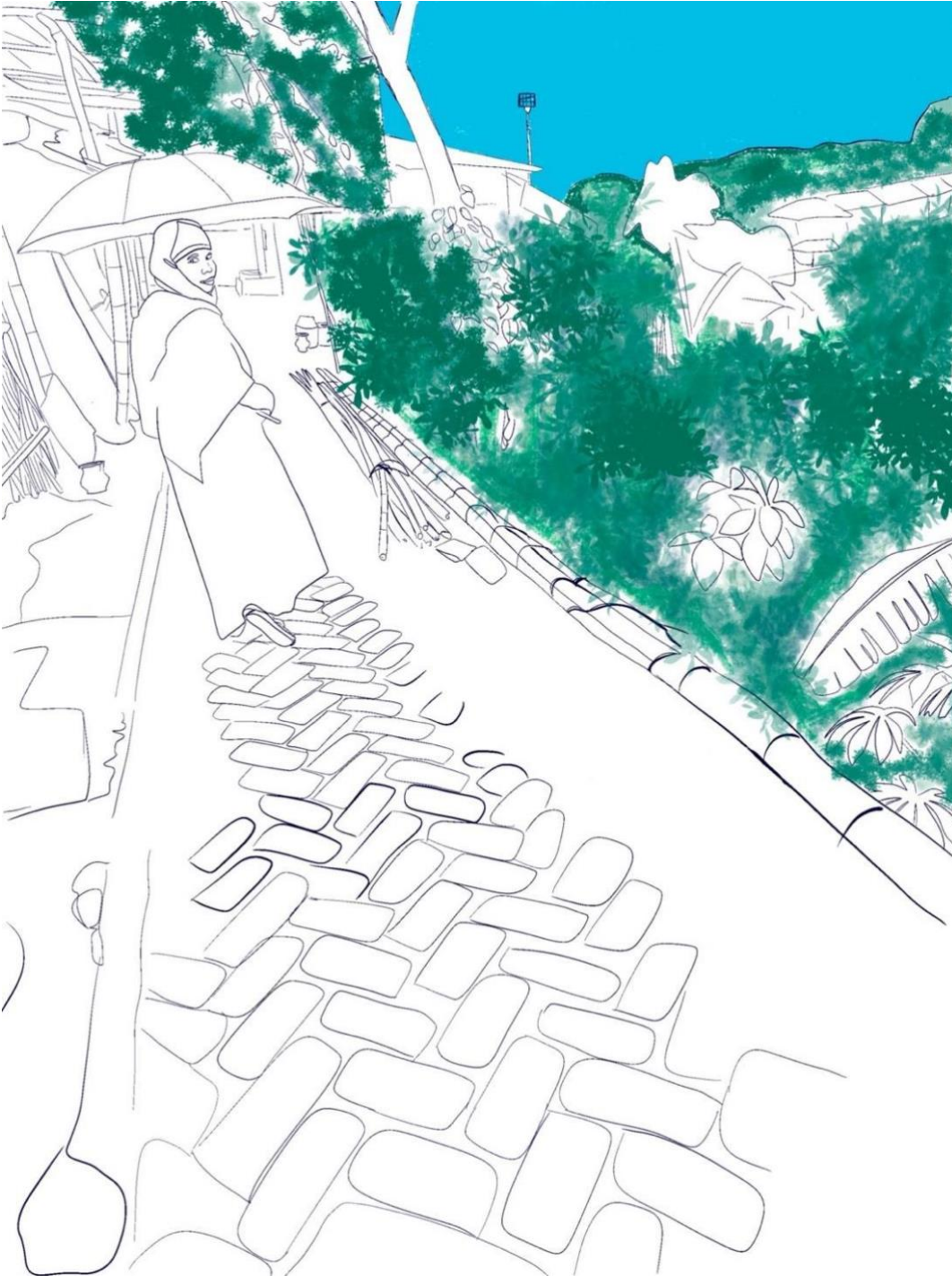


Image 29: A replica of the community health worker, Rubina walking through her block to visit pregnant women in their shelters. ¹⁴⁶

¹⁴⁶ I drew all images of the present work to avoid using the pictures I have taken during my fieldwork and protect people's anonymity.

In a few minutes, we arrive at the other woman's place. Her house appears to be much more furnished than the others. In the room, there is a bed instead of just a carpet and plenty of chairs. As soon as we sit, I realise a new television is on my left. Tonmoy and I sit on chairs while Rubina either sits on the bed or moves around. She seems less at ease than the other two visits, always fidgeting in the space. The woman is sitting at the threshold of the kitchen. She is in the ninth month of her pregnancy and feels unwell. She has received many pills, including vitamins, iron, and calcium, but these have not really helped her. Rubina explains that another community health worker from the Red Crescent hospital in the neighbouring camp contacted the woman as her house is close by. I begin to better understand Rubina's anxiety. The woman chews a pan quid to calm herself and gives one to Rubina as well. A girl enters the house to sell a bunch of vegetables to the woman. A few minutes later, she returns with three cold drinks that the pregnant woman asked her to buy for us.

Rubina goes outside the shelter because another quarrel has just started on the path between a woman with mental health issues and her mother. Her mother is hitting her because she hits her child. Again, since Rubina is outside, we have more space to chat with the pregnant woman. She tells us that she left her village, near Maungdaw, as a child and moved to Bangladesh with her family. She used to live in Chakaria, a town north from Cox's Bazar, but then eight or nine years ago she moved to the camps with her husband. He used to do construction work in Chakaria, but later started working in Kutupalong. She has four brothers and one sister. Her father lives in a camp with her sister, while her mother still resides in Chakaria. Before moving to the camp, she managed to receive a Bangladeshi ID card. Rubina returns inside and tries to convince the woman to deliver at her hospital. The pregnant woman is still unsure, but Rubina says that she will continue visiting her. We leave the house and have lunch at Rubina's.

At her place, we speak with her husband who is very pleased to have us as guests. He tells us that he used to work for an NGO in the construction sector, building latrines and drains in the camps, but after a fight, he remained paralysed. So, he was fired. Rubina is now the only one working in the family, and this situation, as she told me on other occasions, is a recurring topic of discussion and tension between them. We enjoy rice, dal, omelette, tomato sauce, fish, and potatoes. The meal is delicious, and we finish with a Burmese cup of instant coffee. Rubina shows us her house and tells us that she would like to construct new rooms.

Next to the room where we had lunch, there is another room where she stores food. On the left, there is a smaller room where someone may be sleeping; in front, there is a toilet, and on the right, there is a room usually used as a kitchen, where I once sat with her youngest daughter. Their house consists of four rooms, which is bigger than the typical two or three-room houses. Her daughter, along with other four kids, is sitting on the floor and laughing as they watch a video on the phone. The husband interrupts us and says:

“We Rohingyas are bad, we quarrel against each other, why are NGOs helping us? The Bangladeshi government and bubu [i.e., elder sister] ¹⁴⁷ made everything for us. Even if we make shoes with our own skin, we cannot repay Sheikh Hasina’s debt.”

Tonmoy later explains to me that the last sentence spoken by Rubina’s husband comes from the refrain of a Bangladeshi song. The lyrics of the song are slightly different but convey a similar meaning: “A drop of mother’s milk cannot paid back for even if you make shoes with your own skin.” This image delivers an important message that I could regularly observe during my fieldwork: Rohingyas like Rubina’s husband manifest their gratitude towards Bangladeshi people, but would never openly criticise them as Bangladesh has been giving them protection and shelter for years.

I keep visiting Rubina and her family, as well as the RTMI hospital. One day, in front of the hospital, there is a big crowd of mainly women, but also some men, queuing to collect medicines. In the queue, I start talking to an elderly woman who shares her story about her son, who lost his life in Myanmar. Now, only she and her husband are alive, and nobody is earning in their family. She begins to cry when she thinks of her son. I shortly reflect on the condition of some elderly Rohingyas who are not easily employed in the humanitarian response as Rubina and struggle to live in the camp.

Suddenly, Rubina arrives with two community health workers, a young woman and an older one, both wearing burqas. Together, we walk to Nasrin’s, Rubina’s daughter. On the way, we stop at a tea stall, where Rubina buys some bananas and two packets of cakes that she puts in my bag. It is a gift after she received all the delicious dry fish I brought her. Her husband loved it, but her son did not.

Once we arrive at Nasrin’s place, she is holding her newborn daughter, who is sleeping. Rubina tells me that Nasrin and her husband married for love; they met because

¹⁴⁷ The expression *bubu* refers to Sheikh Hasina, the prime minister of Bangladesh from 2008 to 2024.

they are both SMS ¹⁴⁸ volunteers working for the site management sector of the camp. They also have two sons: the eldest is eight years old, and the second is five. Rubina's son and youngest unmarried daughter are also at Nasrin's place. Nasrin tells me about her siblings. I know three of her sisters and one brother. She actually tells me that she has four sisters: two unmarried, one lives outside the camps, and one lives in Malaysia. Rubina asks her, "Why do you talk about them? You should talk about those who are here..." Nasrin ignores her mother and explains to me that her sister went to Malaysia to marry.

While talking, she keeps pushing her finger against her daughter's philtrum, and I ask her why she does it. She explains that it is to prevent her teeth from growing in the wrong direction. She then shows me that she also lightly pushes her daughter's forehead and puts her head on a plate when she sleeps. In this way, her head will not get bigger, she explains to me. Besides, she pinches the upper part of her daughter's nose so that it will not look like a "Chakma's nose." ¹⁴⁹ She shows me a picture of her daughter at birth to demonstrate the difference in nose shape.

Before Nasrin starts cooking, the daughter wakes up. She prepares warm water in the kitchen to bathe her in a plastic bucket. Nasrin gently pours water over her hands and cleans her with soap. The baby cries briefly when she is soaped. After drying the baby with a cloth, Nasrin dresses her in a colourful dress. Nasrin offers us coffee and cake, and then asks if we would like to have lunch together. I reply that we might eat together next week. Nasrin responds that Ramadan will begin, but it will be fine to have lunch next week as she does not fast for the 40 days after giving birth. Therefore, she is not going to fast during the first week of Ramadan like some others in her community like her sons. Children start fasting when they are between seven and twelve years old. We greet them, and Rubina tells us there are currently no pregnant women to visit in the block. One, whom we visited last time, is due to give birth in April. The last woman we visited gave, in the end, birth at the RTMI facility, while the woman with mental health issues delivered at the Red Crescent hospital in the adjacent camp.

¹⁴⁸ SMS stands for site management support and the majority of Rohingyas employed in the humanitarian response are site management sector volunteers. They have various tasks, ranging from construction work to inform the camp-in-charge person about what is happening in the camp.

¹⁴⁹ Nasrin's frequent visits to the Chittagong Hill Tracts explain the reference to the Chakma people and that some of them have flat noses. Her in-laws are Rohingyas living outside the camps in Bandarban, the Chittagong Hill Tracts where Chakma people mainly live.

4. Disease, Death and Certificates like the Birth Certificate

Roshida reveals another facet of social exclusion that involves poverty and abuse, a combination of different layers of exclusion. Roshida is one of the eldest research participants of my research and also migrated, as a mother, before the 1990s to Bangladesh. At the beginning of her stay, she was also living in a village and therefore had no access to humanitarian services in the camps, like Rubina. Around ten to twelve years ago, she moved to the informal settlement camp and a few years later the settlement was recognised as a camp. I visit her thanks to Rubina, who told me her story. After some visits, Roshida starts telling me her sorrows and preoccupations. She has no access to rations due to bureaucratic issues of her documentation – i.e., the data card.¹⁵⁰ Actually, she soon explains to me that family dynamics are involved as well.

Roshida keeps repeating “Allah, Allah, Allah” while crying. She complains that a long time ago she could cultivate, go to the *mura*,¹⁵¹ collect wood and do other housework. When she moved to this area at first, she cleaned the forest but got no food rations. For this month, she still has no ration but due to other circumstances.

Since her son died, “they” went to Bhasan Char and getting rations is now difficult. Once she points to her data card, I better understand what she is talking about. The family card or data card displays all the family members and indicates their names and general information (as shown in the replica on the next page, image 30). It is used during the distribution of food or to access other services, and it is often conceived as an identity document in the camps. Without a data card, Rohingyas cannot access any services in the camps. Roshida’s card has only her picture on it because the other images were crossed out with a black marker. Her daughter-in-law and her children resettled to the island of Bhasan Char some months ago. Since then, they have been receiving an extra ration of food because they did not inform authorities that Roshida stayed in the camp and did not move with them. Because they received Roshida’s extra ration, she has not been able to collect her food ration in the camp. Her daughter-in-law left the camp and settled with her children to the island of Bashan Char where the government of Bangladesh promoted with the UNHCR the resettlement of Rohingyas. Roshida stayed in the camp to take care of her seriously ill son, who had a tumour in his brain.

¹⁵⁰ General information on the data card regard name, sex, date of birth, the relations among family members (such as, wife, son and daughter) and two ID numbers.

¹⁵¹ *Mura* means mountain or hills.



Family Attestation পরিবারিক প্রত্যয়নপত্র



This document certifies that the person(s) below, whose photograph(s) appear(s), is/are Forcibly Displaced Myanmar National(s)/Person(s) of Concern to UNHCR registered by the Government of Bangladesh. They should be protected from forcible return to a country where they would face threats to their life or freedom. The bearer(s) has/have the obligation to respect national laws. All questions relating to information contained in this document may be addressed to RRRC/UNHCR. For any queries contact Tel : +880 000 00000

FCN No: XXXXX

Case No: xxx-xxxXXXX

Size: 0

Camp Address: xxxxxx

/ Camp 00

Full Name	Sex	DOB	Rel to HRL	Status	MOHA ID	progres ID
01 Name	M	01-Jan-1990	PA	A	0000000000000000	000 00000000
02 Name	F	01-Jan-1990	WIF	A	0000000000000000	000 00000000
03 Name						



01 Name



02 Name

STAMP

Signature

STAMP



Printed On: Tuesday, 01 Jan 2020 @ 10:00:00

Signature

Linked FCN No: 000000, 000000

Secure Paper Serial No: XXXXXXXXXX

Image 30: A replica of a family data card.

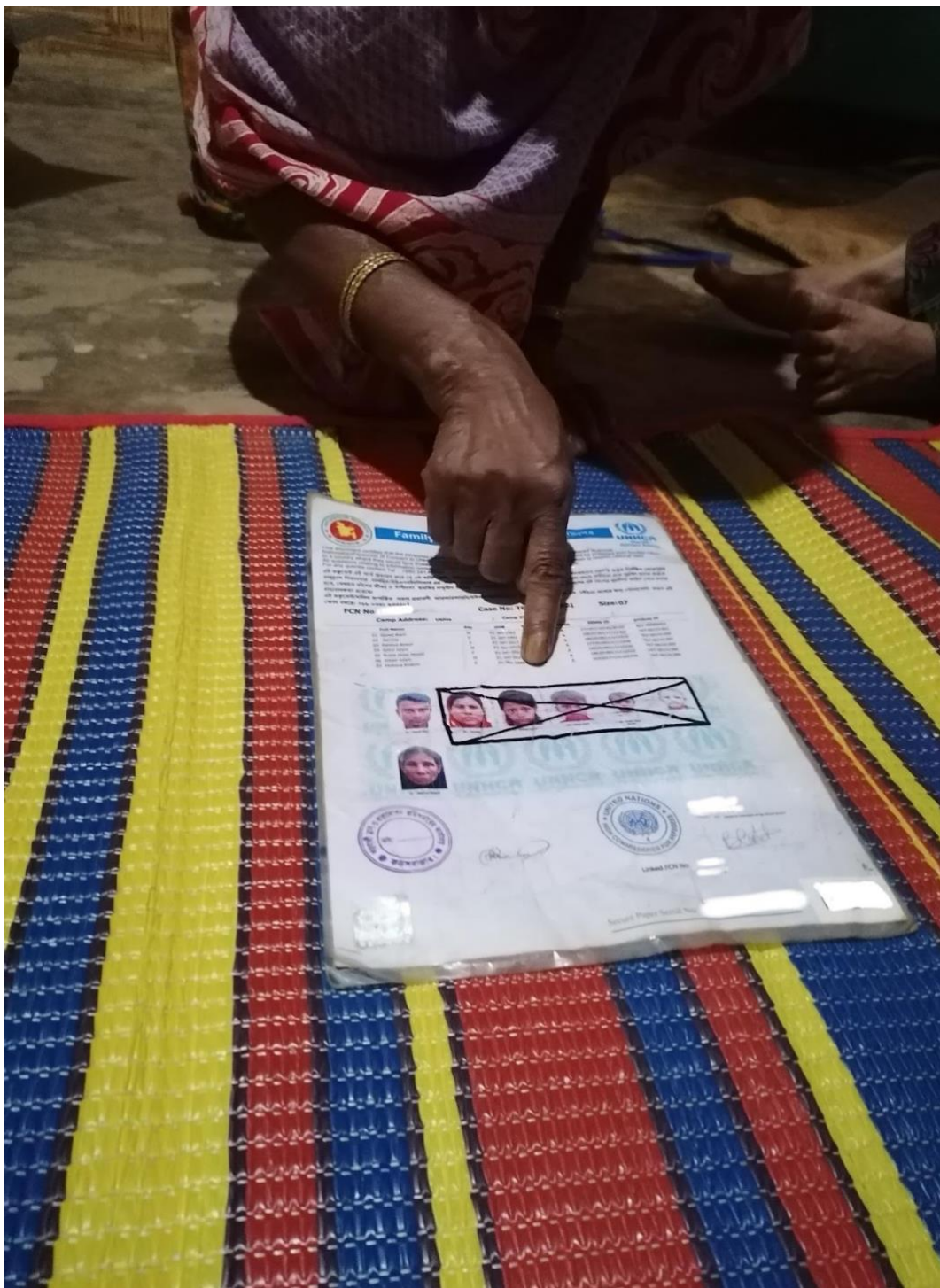


Image 31: Roshida showing me her family data card.

After the tumour in her son's brain was discovered, and treatment in Dhaka turned out to be too expensive, her daughter-in-law and grandchildren left. Her son died just two months ago, although Roshida looked after him till the end and "pumped water for him until her hands were hurting". She says:

“My son always said that he was having headache. He took treatment from many places nearby [...] until the hospital referred him to Chittagong! [There] he met a doctor who asked him to go to Dhaka, to a private hospital. He never received any surgery there, but once back to the camp he kept suffering. He was acting insane and was losing eyesight day by day. I think it’s all by the order of Allah.”

(R., personal communication, 23 May 2022)

Roshida explains to me that he received treatment from several nearby hospitals until he went to the public hospital in Chittagong. There he met a doctor who advised him to go to a private hospital in Dhaka. Roshida tells me that, at the beginning, her daughter-in-law and the people of the camp tried to help him financially but they were unable to pay for his operation. This money was used to pay for his funeral. I kept visiting Roshida, who, on other occasions, never attempted to explain her son’s death apart from saying that it was Allah’s intention. The sudden death of Roshida’s son, after the apparently unreasonable transfer from a public health facility to a private one, was tragic. The fate of this patient who could have not afforded expensive treatments appeared quite intricate to me. Everybody attempted to be supportive in his deteriorating situation. Roshida explains:

“My son used to work as an auto-rickshaw driver, he had some savings. He also had worked in brick fields. My daughter-in-law had some gold jewellery, such as a gold chain, a nose pin, some earrings and bracelets. She sold everything! I cleaned the offices of an NGO under my daughter-in-law’s name since I am too old to do the job, but I worked instead of her. She got 8,000 takas from some relatives in Malaysia.¹⁵² The block *majhi* asked people of this block to help.¹⁵³ Some gave money, some rice and other things.”

(R., personal communication, 23 May 2022)

At first, he was treated in the public Chittagong hospital and then transferred to an expensive private facility in the capital city. Roshida did not know the reason for the transfer. Hence, my research assistant and I discussed at length that he was subject of trafficking for the purpose of organ removal. In fact, he went to Dhaka even though he did not have the money for the operation. Since he came back from this journey, his health deteriorated quickly.

¹⁵² BDT 8,000 correspond roughly to € 70.

¹⁵³ *Majhi* means “boat captain”, but in the camps the term indicates Rohingyas who, appointed by the Bangladeshi military, assumed a leadership role. Responsible for each block or sub-block, the role of the *majhi* has been recently contested. Due to their proximity to the police and military, the *majhis* seem to have abandoned their initial tasks of pursuing Rohingyas’ interests in the camps (ACAPS, 2018).

Other families in the camp told me many stories of trafficking. I found no reference to organ removal in that particular case but unearthed quite a lot of documentation about the inadequacy of anti-trafficking law in the country (Fatima & Yea, 2023). Still, this example shows that the deteriorating living conditions for Rohingyas in Bangladesh exacerbate their precarity to the extent that their coping strategies may lead to dangerous choices. Whilst the incident involving Roshida's son does not indicate any abuse or organ trafficking - as this is merely a hypothesis - it highlights that Rohingyas in the camps are subjected to multiple exclusionary dynamics affecting their lives. Finally, Roshida's daughter-in-law who moved to Bhasan Char without indicating to authorities that Roshida had stayed in the informal settlement camp shows the relevance of certificates for Rohingyas to survive in the camps. Certificates are also crucial at birth.

At the primary health centre in the informal settlement camp, Roxana, the supervisor of midwives at the RTMI hospital, explains to me that one month after birth, the clinical manager of the hospital and the camp-in-charge person will sign the birth information note for the newborn. As picture nine shows, the clinical manager signs the birth information note, followed by the camp-in-charge person. In addition to collecting the personal information of the newborn, the birth registration note serves to enable institutions to register the newborns delivered at the health facility. The form can be used only for facility-based births. Once the camp-in-charge person signs the note, the United Nations High Commissioner for Refugees' (UNHCR) office issues the birth certificate. The birth certificate is of vital importance as it entitles the newborn to be registered, included in the family data card and access all camp services, including food rations.

If the birth occurs at home, the note is not signed, and the newborns will face problems because they will not have any certificates. As a consequence, these children are not registered in the camp for an unknown period of time. Eventually, the camp-in-charge person will register them, especially if the family's demands persist, but without any guarantees. According to midwife Roxana, home births are not registered to punish the Rohingyas for child marriages. She refers to the fact that a very young woman would rarely deliver her child in a hospital due to the fear of being reproached by the medical staff.

Despite experiencing the denial of birth certificates for their newborns delivered at home, Rohingya women in the new camps prefer to give birth in their shelters with the assistance of a *dhoroni*. I cannot understand why so many women continue to give birth at home. On the one hand, the rule forbidding home births has just been implemented. On the other hand, Rohingyas seem to be quick in spreading information by word of mouth about the introduction of new rules in the camps. In fact, Rohingyas are aware of this rule in the health sector, but have not been convinced by community health workers to attend the health facilities. Humanitarian organisations have implemented this rule - such as the United

Image 32: The clinical manager and the camp-in-charge person must sign this birth certificate form for facility-based births to have a birth certificate issued.

Nations Population Fund (UNFPA), the IOM, the RTMI and Save the Children – with the aim to save lives and therefore encourage women to attend health facilities in the camps. Instead, the government appears engaged in hospitalising deliveries to control, manage, and promote family planning programmes.

5. National Humanitarians' Approach to Family Planning

Through Rubina's words and attitude towards births, I am able to look at the new dynamics triggered by the humanitarian response and the presence of NGOs in the informal settlement camp. Rubina is directly employed at the hospital as a community health worker, being fit enough for daily walks around the camp and fluent in the local Chittagong language.¹⁵⁴ Therefore, she can interact very well with Bangladeshi nationals employed by

¹⁵⁴ As explained in chapter 5, Rubina has lived for years in a village (where some of her relatives live) and then moved to the makeshift settlement, recognised as a camp in 2017.

NGOs in the health sector. They still regard her with a top-down attitude, but she does not give much importance to this behaviour. She is one of the few privileged Rohingyas employed in the humanitarian response, whereas nationals are numerous in the management of the services in the camps.

During her daily walks around the block, she gets to know all the pregnant women living in the area, as her task is to visit their shelters in the camp and convince them to give birth in the hospital. In this way she can explain what services are available to them in the healthcare facility, she spends time with them and understands their conditions. She accompanies them during labour and stays in the hospital to assist them, in case she has time. For the hospital assistance, this is the responsibility of Naslima and Amina, two *dhoroni* appointed as birth attendants in the health facility. As community health worker, Rubina does not intervene during hospitalised deliveries, and she is no longer allowed to assist with home births, as she used to do previously.

In February 2022, her daughter Nasrin gave birth in the hospital, as she had “to set an example” for the community. Her two older sons were born at home, thanks to Rubina’s presence. Nowadays, in her role as a community health worker, Rubina has convinced her daughter and other women to give birth in the healthcare facility as the only option, as it is her responsibility to fulfil her duties and tasks introduced with the humanitarian response.

In the informal settlement camp I am stopped by Rubina. In her role as a community health worker she has postponed the meeting with pregnant women on family planning until today. Rubina shows me the house where the meeting will be held in her block. I meet the paramedic supervisor of the RTMI facility, who is responsible for the informal settlement camp, a new and an old camp. The supervisor is from Dhaka, and her name is Saila. During the meeting, Rubina acts as an interpreter for Saila and the outreach worker, who also comes from outside Chittagong. At the end of the meeting, they also provide some snacks to those who would otherwise not have taken part. The practice of snack distribution by NGOs to attract Rohingyas to attend their meetings is quite common in the camps. The meeting is an awareness session on family planning and on antenatal as well as postnatal care within the framework of reproductive health.

In the beginning, there are only seven women with seven children in the room, but a minimum of ten women is required for the meeting to commence. Rubina brings three additional women, and at 10:30 am the meeting starts. Various points are made, such as the importance of the 24-hour check-up after delivery and the other check-ups during

pregnancy. Services at the hospital are available for forty-two days after delivery when family planning methods are highly recommended.

The supervisor looks at me with a big smile on her face and explains that Rubina is translating what she has just said because she understands “our Bangla language so well”. The woman has an attitude of superiority towards the Rohingyas, and in her speech, she compares the latter to her mother and grandmother. They are like women of the past. She says, “Like my grandmother who used to give birth to so many children!” Rubina keeps translating and diplomatically laughs at the supervisor’s jokes.

They talk about scabies, as the diffusion of this skin disease in refugee camps has turned into a serious problem.¹⁵⁵ They talk briefly on how to prevent it through washing routines. They discuss the *gusol* (i.e., bath for menstruation) and the importance of daily showering. “As if we have enough water in the camp!”, adds Rubina, who bursts out laughing. The supervisor keeps mentioning the various family planning methods available in the camp, such as the pill and intrauterine device. She asks each of the ten women (between 19 and 30 years old) how many children they have. Then, she concludes that I look good because I do not have any children, whereas they will not be as beautiful if they continue having so many pregnancies. Rubina shows them a book and its drawings to convey the idea of family planning through a much more convincing argument. In the first image a person holding all his family members over his head looks at ease, as these consist of his wife and two children, whereas the picture on the right shows him in the same position struggling to give the message that metaphorically he cannot take care of five children and his wife (see picture ten). Nationals working for health facilities have led to a diffuse implementation of family planning programmes, which are presented as a priority in Saila’s paternalistic attitude.

The humanitarian response aims to medicalise births to ensure maternal safety and reduce mortality in the refugee population. Nevertheless, the work of Bangladeshi humanitarians, by and large, appears to promote the implementation of family planning programmes. NGOs’ goal to support facility-based deliveries in order to reduce the rate of maternal mortality in the camps appears to intermingle unintentionally with family planning policies, which are offered to Rohingyas as an option straightforward after their deliveries. Rohingya community health workers, like Rubina, support these policies in the informal settlement camp, whereas birth attendants like Naslima and Amina are seldom involved in

¹⁵⁵ Scabies outbreak worsened in 2023 (Médecins Sans Frontières Australia, 2023).

family planning policies, but their presence encourages more Rohingya women to attend the health facility to give birth.



Image 33: The community health worker, Rubina explains family planning methods to a group of Rohingyas during a block meeting.

6. Rohingya Birth Attendants in the Primary Health Centre

I regularly visit the RTMI health facility and have been able to assist together with Naslima and Amina the births of some Rohingya women like the one of Latifa.

I am finally able to spend some hours in the antenatal care (ANC) room, where four Bangladeshi midwives check pregnant Rohingyas. The supervisor of the midwives explains to me that “ANC” stands for eight visits planned according to the gestational weeks of the pregnant woman. After each woman's check-up, her measurements are recorded and she is weighed each time. The hospital is open 24/7, and eight midwives alternate between morning and evening shifts. They continue with the check-ups and explain that if a woman's upper arm is thinner than 22 cm, they will refer her to the nutritional site of the camp. Roxana, the supervisor of the midwives, tells me that in the morning two vaginal deliveries happened. Midwives cannot follow up each delivery because there are 30 to 40 antenatal care visits to accomplish per day and right now, one woman is in labour, but all the midwives are busy with ANC appointments.

The next woman who comes in for the antenatal care routine visit is in her fifth month of pregnancy and has a serious skin condition, which the midwives do not address. She is with her three-year-old daughter and one-year-old son. Therefore, a midwife suggests she return for family planning after this pregnancy, advising that she should wait at least three years before having another child.

I go to the labour room where there are two new mothers who delivered in the morning, along with their mothers and the newborn babies. There is also one pregnant woman. The pregnant woman has mental health issues and is on her own; her husband is probably at home with their two other children, Roxana explains to me. The woman does not want to eat because her mouth tastes bitter. She has no uterine contractions that would cause the dilation of the cervix. Roxana performs pelvic palpation to check the baby's position, which is in a cephalic position. After this reassuring check, the pregnant woman eats some rice and a tiny portion of vegetables. She is fed by one of the mothers of the other pregnant woman who sits next to me. This mother, along with the other pregnant woman's mother, discusses the pregnant woman's irresponsibility, which they attribute to her mental issues.

The Rohingya birth attendant, Naslima, comes in and suggests that the pregnant woman walk for a short while and then sit with her back against the wall. A community health

worker arrives to inform the pregnant woman that she can call her family members, and soon after, her sister-in-law joins her. Naslima takes care of her and tells her to lie down on a bed in the labour room. A midwife enters to perform an ultrasound while Naslima gives her a lower back massage. Naslima explains to me that the pregnant woman has four children; two have died, while two are alive. She continues to massage the area around her tailbone and recites holy verses to alleviate her pain. At 3:30 pm, I leave the primary health facility as I am not formally allowed to stay longer, even though the pregnant woman has not yet given birth. I frequently experience the frustration of having to abruptly interrupt my observations, interactions, and conversations in the camps. This limitation is a recurring theme in my field notes, and I have not always been able to keep track of the development of certain events, such as the pregnancy of this woman.

Days later, I arrive at the primary health centre and go directly to the delivery room. One woman is in labour, laying on the floor, as many Rohingyas use to give birth at home. I am asked to sit on the floor behind Kojida, the pregnant woman, and place my feet as support to hold her back. Two Rohingya community health workers employed by the hospital are at the pregnant woman's side, and the birth attendant sits in front of her. We are actually in the position that relatives or neighbours must take to support a woman during her labour at home.

A Bangladeshi midwife comes into the delivery room, and Kojida surrenders to a large wooden birth chair, where the baby is finally born. He weighs 2 kg and 600 g. The midwife cuts the umbilical cord even though the placenta has not yet been expelled. She checks the mouth, ears, and nose of the newborn. The baby cries and opens his eyes only ten minutes later. I know this because the birth attendant, Naslima, gives me the baby so I can carry him out of the room while they continue the delivery of the placenta with the fan switched on. The baby is, of course, extremely sensitive to sounds, light, and even the wind on such a hot day; for this reason, the fan is off for the first two phases of the delivery. How will he survive in the camp? I ask myself, and then simply answer that he will somehow handle this, as almost everybody does.

In the delivery room, initially, Kojida is about to give birth like at home until the midwife arrives. This encounter with the midwife not allowing her to give birth on the floor is alleviated by the *dhoroni*. The pregnant woman, Kojida has to “surrender”. Once the midwife enters the delivery room, Kojida has to give birth on the birthing chair instead of squatting or standing. Besides, the midwife cuts the umbilical cord and breaches Rohingyas' beliefs and

practices, while the *dhoroni* remains self-assertive by navigating the dynamics of the hospital. Based on the conversations with other *dhoroni*, the umbilical cord is not cut until the placenta is expelled and the baby breathes because Rohingyas believe that the baby's soul is still in the placenta and needs warmth and time to migrate to the baby's soul. Naslima and Amina engage in different tasks, both working as birth assistants at the health facility in the informal settlement camp. By observing them in the hospital, I notice that they still adhere to some old practices when assisting a woman during childbirth, whereas many procedures are carried out due to the influence of NGOs. As Naslima paraphrases this:

“Before, we did not make the pregnant woman walk. But now we make her walk. I make her drink water and train her how to push. We give her tea, rice and bananas so that she has energy. Then, once the time approaches for the delivery, we make her lie down... We get her to lie on the floor, and in this position, we make her push. Then, in this way, we take the baby out and... Before, we used to... Since there was no blade and no scissors at the time, we used a very sharp part of the bamboo to cut the cord towards the north. To cut the cord, we tied it with a thread and then cut it with the blade or with the *dholu*, (“thin and sharp external part of bamboo”). [...] At the time, there was no concept of check-ups. So, if anyone in our area called me, I would go and attend the birth at home. Even after the birth, the day after, I used to bathe them and do what they needed. [...] *Oillo*, fire, and we used to ask the women to get warmth from the fire at the front and the back of their bodies. Now there are doctors; at the time, there were no doctors available, so that's why we asked them to heal through fire.”

(N., personal communication, 28 September 2022)

It is in the hospital of the informal settlement camp where I have heard for the only time the direction in which the umbilical cord is clamped. The reference to the somewhere in the north most likely is related to Mecca and, more precisely, towards the Kaaba. Muslims face this direction in prayer and other rituals.

I meet Naslima more often than Amina, as the latter works during the night shift. Naslima is between 40 and 50 years old ¹⁵⁶ and has two sisters: one lives in the Kutupalong registered camp, while the other lives outside the camps along the main road to Chittagong. She used to reside in Cox's Bazar until she decided to move to the informal settlement.

¹⁵⁶ Only a few people in the camps knew their exact date of birth and age.

I soon also meet Amina and discover that she has a story similar to Naslima's. She complains that living in an environment where Bangladeshi people constantly discriminate against them is exhausting. She expresses deep grief, especially in relation to her experience in the *mura*, or hills, which indicates the time when their camp was still a makeshift settlement. They have lived for years outside the camp system and faced pressure from Bangladeshis.

Both Amina and Naslima acclaim their learning experiences in Myanmar, where they were initiated into midwifery by their relatives or learned on their own. On the other side of the border in Myanmar, Rohingyas and other discriminated minorities have no access to hospitals or to the formal curriculum for midwifery. However, some *dhoroni* still hold a certification of their competencies after attending training courses with various NGOs. More specifically, the majority of Rohingya birth attendants – known as *dhoroni* or *fuwa dhoroni* in Rohingya idiom – are uncertified but have learned through experience, which is a crucial resource for them.

Furthermore, they have lived for a long time in a context where humanitarian social actors have been present in their region of origin, and many of them have received special training from humanitarian organisations in Rakhine State. This training corresponds probably to the courses for birth attendants that global policies introduced worldwide between 1980 and 1990 (MacDonald, 2022). Naslima continues following certain principles in the camp that she learned from her mother:

“My *dadi*, paternal grandmother was a *dhoroni*, and my mother was also a *dhoroni*, so when my mother went to any delivery, I went with her. I was always there when she was helping with the delivery. I used to observe how she did things and what she did. One day, there was an occasion when my elder brother's wife was delivering at home, and she was suffering, but my mother was not at home since she had gone to visit my sister who lived far from our area and I told my sister-in-law, ‘Don't worry, I am here, and I will be able to do it.’ Then, my sister-in-law didn't pay attention to me because, at that time, I didn't even have my period yet. I was very young, and she was making fun of me because she didn't trust me or my abilities, so at that moment, I did it! I made it!

After that, the people around me began calling me when there was a delivery, and I did deliveries for almost three years! At one point, my mother enforced restrictions on me and told me, ‘You won't go for any delivery as long as I am alive: you won't go for a delivery

without my permission.’ Then, I didn’t do deliveries anymore because she imposed restrictions.

One day, there was flooding, and someone came by boat to our house. I then sent my father to ask who the man was. The man said, ‘I am looking for a *dhoroni*; my wife is pregnant and suffering.’ I thought I would go, but my mum got out of bed, and she was all right! ‘Make some betel nut for me,’ she said because she had never had anything to eat from the pregnant mother’s place as it was unethical. I also used to do the same when we were back in Myanmar.

The baby’s position was straight in my first delivery; that’s why I was able to deliver successfully. If the baby had been in a different position, I would not have been able to deliver, but I learned. At the time, I could manage it and called my brother’s wife’s younger sister to assist me and hold the belly in this way so that the baby stayed straight, allowing me to proceed with the delivery. Now, women are referred to the hospital ... nurses [midwives] refer all pregnant mothers elsewhere if there is any kind of complication, but we *dhoroni* could easily deal with it. In Bangladesh, we cannot take the risk anymore because if there is an accident, they will blame us. That’s why we let it go.”

(N., personal communication, 31 August 2022)

Naslina talks about the importance of not being paid for her job, but this rule applies to Myanmar. At the time of the interview, she is employed at the primary health centre. She is not taking any money from the pregnant women, but the NGO pay her monthly. Besides, in her words, a clear distinction between the *dhoroni* and midwives emerges. The midwives are anxious to intervene in emergencies and take less responsibility by delegating their work to either Amina or Naslima. Naslima highlights that, as an employed birth attendant, she has to accept that she cannot deal with more complicated deliveries and has to “let it go” in this new context of the camps despite her long experience. She has assisted with deliveries ever since she was a child, like her colleague, Amina, the other employed birth attendant, who tells me about how she has learned to assist pregnant women in giving birth:

“My husband’s paternal grandmother was a *dhoroni*. But suddenly, she had an accident, and she had problems walking due to hip and leg issues. Shortly afterwards, my husband’s aunt went into labour, and at that time, her mother – my husband’s paternal grandmother – asked for me. ‘I will show you how to do it, just come with me! I will show you how to do it’, she said. I followed her, and she was led to the spot by some people. She showed me how

to do it, and I did it. Just after the delivery, I was called by many other people to do other deliveries.

After almost two weeks, there was another accident involving the family's cow, and the calf died in the womb. They requested that I deal with it. Under the supervision of my husband's paternal grandmother, I was given a blade. She showed me how to use it and where the calf was situated inside the womb of the cow. I felt with my hand where the leg was and used the blade to cut around its joint and cut through. Then, I took out the leg first. I also used the blade to cut around the hip and brought it out. I took out both legs, then the body, and the upper part of the body. I used another strategy to pull the head from the body, and this came out. The mother cow fell and lay down because it was exhausted at the time. [...] It was the year I reached puberty. Maybe I was twelve years old."

(A., personal communication, 31 August 2022)

These stories highlight the life experiences of birth attendants who, as teenagers or since a very early age in their lives, needed to take over great responsibilities because they lived in a context of segregation in Myanmar. This enabled them to become profoundly experienced in their role of *dhoroni* by being acquainted with technicalities, rituals and certain principles, although they were never allowed as Rohingyas to attend any formal midwifery curriculum.

Both birth attendants are hired in the RTMI primary health centre. There, NGOs' knowledge is authoritative and they are supposed to follow standard practices.

"Some women are scared of going to hospital, but we make them understand that they don't have to be fearful because we are here! You are Rohingya, and we are also Rohingya, so we will take care of you more than your parents would."

(A., personal communication, 22 September 2022)

The medicalisation of births in the camps has been implemented such that all *dhoroni*, whether employed in the health sector or not, have been asked to stop delivering at home. This exacerbates tensions among humanitarian social actors, the government, and the Rohingyas, although it appears that the camp has recorded a slight increase in home births. To alleviate some of these tensions, a growing number of health facilities have employed young Rohingya *dhoroni* as community health workers like Rubina to inform refugees about the healthcare services available in the camps. Community health workers are also tasked with bringing pregnant women to the hospital for childbirth and informing them about family

planning methods (Azad et al., 2022). In this way, they gain a new social position in the camp. Since their tasks contribute to achieving the goal of more hospital births, the medical personnel value their roles, whereas birth attendants are often taken for granted in the settings of the hospital. Birth attendants have been directly employed in some health facilities to serve a mediatory role during deliveries, assisting and supporting pregnant women in labour. In a tacit agreement with Bangladeshi midwives, they carry out deliveries since these midwives are frequently in the early stages of their careers. Two birth attendants are employed and still constitute a minority compared to the fourteen community health workers of the health facility.

7. Concluding Remarks

The birth of Latifa illustrates the poor behaviour that some medical personnel exhibit towards pregnant women in this first camp. Bangladeshis tend to regard Rohingyas as uneducated, reluctant to attend prenatal and postnatal care check-ups, and hospital deliveries, just because they are illiterate. Walking with Rubina throughout the camp enables me to meet several pregnant women who are aware of the peculiarities of Bangladeshi society. I get to know common practices, topics of discussion and cultural values among Rohingyas. In the context of the camp, Rubina appears to be privileged in her role of community health worker as she earns a monthly salary. However, Bangladeshi workers treat her scantily. Furthermore, Bangladeshi midwives seem to act more superficially than the two birth attendants working in the hospital who make sure that pregnant women are protected. The two *dhoroni* discuss their challenging life outside the camps, both in the makeshift settlement and in “Burma”, where they lacked access to hospitals and education. As teenagers in Burma, they had no choice but to assume great responsibilities while absorbing technical knowledge, rituals, and principles. Now, their knowledge must align with global health policies, and they follow this way of delivering in order to be respected in the hospital and encourage pregnant women to attend the health facility. Home deliveries have been prohibited in the camp, leading to tensions when they still occur. In these circumstances, authorities punish Rohingyas by not registering them. The importance of certificates is shown also through the story of Roshida and her son.

A hierarchy of knowledge persists in the primary health facility of this camp where, although the number of children born in the primary health centre appears to be increasing because Rohingya birth attendants and community health workers work there, the role of employed Rohingya women is marginal as they are considered illiterate women. Rohingya

women have experienced various forms of social exclusion in the camp, such as the non-recognition of their role in the hospital, of their status, and the denial of certificates if they give birth at home. In the field of reproductive health, nationals discriminate against Rohingya women by not recognising their contribution to the medicalisation of births in the camp.

CHAPTER SEVEN Rohingya Women's Strategies during Home Births in the New Camp

1. Introduction

The present chapter argues that home births among Rohingyas in the new camp are prevalent as most of them arrived in Bangladesh in 2017 and therefore are much more mistrustful of the humanitarian system. Besides, the community health workers are not able to reach and convince many families to attend the primary health centres, also because there are less NGOs in comparison to the informal settlement camp and the new camp is isolated – i.e., there are no adjacent camps. Generally, Rohingyas avoid hospitals due to the way local medical workers and Bangladeshi midwives treat them, but they rarely address this issue directly. Within the structural challenges - such as a lack of respect for rights, isolation, and encampment – and the exclusionary discourses affecting the Rohingyas, a widespread narrative is common among the local population. They are biased against the Rohingyas who are often represented as “uncivilised”. For instance, the expression *tumi Rohingya* is used to hurl insults at people and it represents this exclusionary attitude. In the Bangladeshi language, three forms of the second person pronoun “you” are available, and *tumi* (তুমি) is its intimate version, which, if used for strangers, constitutes an insult. Hence, *tumi Rohingya* is a common expression used by locals to insult people.

In the domain of reproductive health in the camps, instead of using the Rohingya word *dhoroni*, words from global health policies like “community health workers” and “traditional birth attendants” indicate birth attendants employed, for example, in the primary health centre of Save the Children in the new camp. The differentiation between birth attendant and a community health worker is not drawn in this health facility of the new camp. In fact, there is no Rohingya like in the informal settlement camp who directly assist women during hospital deliveries. Finally, *dhoroni* in the camp continue assisting pregnant women at home if they are not employed in the health facility. This is the case of Aicha and Fatima, who assist births at home in the new camp.

Several women prefer to deliver their children at home, although institutional social actors have prohibited home births to ensure “safe births”. Children born in their shelters are denied birth certificates and access to basic services. Through the specific case of Rohingyas who decide to give birth at home, this chapter addresses one of the pregnant women's responses in the camps to the different layers of exclusion affecting them in the

domain of reproductive health. Births at home intertwine with an overall sense of protection that does not uniquely stem from the place itself, but involves relatives, neighbours, and birth attendants. This network acquires a crucial role in leading women to give birth at home. Because of the institutions' opposition against home births, unemployed *dhoroni* rarely called me to attend a birth at home; however, I am eventually able to observe the three phases of birth at home twice. These phases include the beginning of labour and the arrival of the *dhoroni*, the expulsion of the foetus and the placenta, and the preparation for healing practices to support the mother in the postpartum phase. The following section describes my participant observations from fieldwork.

2. Giving Birth at Home in the New Refugee Camp

At 10:15 am, the pregnant woman's husband picks us up in block E of the new camp. On the way to his place, he tells my research assistant Dihan and me that his wife started having pain very late at night, around 1 am. Also the *dhoroni*, Fatima, has informed me about the home delivery and expressed her concern regarding the time factor by referring to the prayers of the day.¹⁵⁷ I did not expect her call: A couple of days ago, she told me that she had declined the request of a pregnant woman to be assisted during her delivery at home because she was tired. We join Fatima in the bamboo house constructed with the support of an Arab country, and we meet three women sitting in the first room at the entrance.¹⁵⁸ They are the mother-in-law of the pregnant woman, the mother-in-law's sister and her daughter-in-law's sister. Three children noisily play together in the room. Additionally, another woman, who is a neighbour, comes to assist the pregnant woman in labour. We sit on the floor of the main room with them for a long time. The mother-in-law's sister tells us about her sister's son, who works as a *hafiz*, namely, as a person who memorises the Quran and teaches in the religious school, an important and respected person, who pays her the rent (*jaighir deowa*) to hold his school in her place. From 3 a.m. to 7 a.m. and then, after the break, until 10 a.m. he has one class and another from 7 p.m. to 10 p.m. She also talks of the *moghorib* prayer, which corresponds to the late class at sunset. This gives me a general idea of how Rohingyas spend time when I cannot visit the camp.¹⁵⁹

¹⁵⁷ Such as, the *fojor/fozor* (morning), *juhur/zuhur* (in the late morning), *hasor* (in the afternoon), *moghorib* (during the sunset) and *heshar/eshar* (at night).

¹⁵⁸ As mentioned in chapter 5, various Arab countries have financed part of the Rohingya response in different domains, given the prominence of Rohingya and Bangladeshi migration on their territories.

¹⁵⁹ Visits in the camps are allowed from Sunday to Thursday, 9 a.m. to 3:30 p.m.

In the other room of the shelter lies the pregnant woman, Tasfia. At first, she invites us to come inside, but after a while, she asks us to return to the main room because she is shy. One of her sisters-in-law sits with us while we wait in the main room and tells us about her two daughters and one son. The room's ceiling is covered with two umbrellas to prevent the rain from coming in, as the ceiling is broken. Fatima, the *dhoroni*, sits next to us and explains that during the *fojor* prayer, she was called by a man and a woman to assist with this delivery at home. Her son was still sleeping then, and now she is not even sure if he has had breakfast. We are allowed to return to the kitchen, the second room, where the pregnant woman is lying down, and one of her sisters-in-law tells us that she used to chew a lot of *paan* - i.e., betel nut. But then she had breathing problems and pain under her chest, as well as in her back. She used to have the same leg pain when she had her period. So, she has quit chewing *paan*.

The pregnant woman drinks some tea to gain energy. The family members tied the *rosi*, rope, to the ceiling, with a piece of cloth at the end. Later on, pulling the *rosi* while standing will allow the woman to push more efficiently. Tasfia's sister-in-law tells me that the hospital in the new camp is also equipped with a *rosi*. Next to Tasfia's feet, there are also two heavy flat stones so she can later push her feet against them. Behind her, on the floor, there is a large bag of rice and a pillow so she can exert pressure with her back. Four women are around her, together with Fatima, who explains to me that during the rainy season, it is not easy for a pregnant woman to heal after birth. Indeed, the weather is not dry enough to support her healing.

Tasfia already has one daughter, who is one year old. By contrast, she does not know her own age, but she can guess because she received her period nine months after marrying two years ago. Hence, she is probably 15 years old. In this way, by recalling essential life events, she pieces together information about her age.

At a certain point, a woman wearing a veil and a name label on her chest approaches the shelter and stands on the threshold of the entrance room. She asks questions about my job and introduces herself: She is a community health worker from the village next to the camp and works for the International Organisation of Migration (IOM) hospital. She wishes to see the pregnant woman. Fatima becomes afraid, and Tasfia's mother-in-law starts to wonder whether she should take Tasfia to the hospital, as the community health worker suggests. Fatima, the *dhoroni*, discourages her while the community health worker tells her she will help them at the hospital. Fatima goes into the other room to talk privately to Tasfia's mother-

in-law and asks her not to mention her name in front of the community health worker or other doctors. As soon as the community health worker follows the two women into the other room, Tasfia whispers: "The CHW gets more money if she takes me there... I don't want to go." Anyway, the arrival of the community health worker makes the situation very tense. We go to the main room where the group of women is talking about Myanmar, the war and the possibility of returning to Arakan.¹⁶⁰ Fatima intervenes, pretending to forget about the present situation with the community health worker: "We cannot go back since the war is still going on! Our houses were burnt; where shall we go?" The discussion continues until the pregnant woman enters the room and interrupts them by saying she has just spoken to the community health worker and sent her away. She told her that she was doing fine and probably would not give birth today. The mother-in-law's sister continues the *adda* (which Chakrabarty, 2009 explains and translates by the term "gossip") by recalling her migration to Bangladesh with her sister from Burma. Her in-laws and her family live in other camps. Not many women in the camps live away from their in-laws, but this is much more common in this camp.

It is 1:10 p.m. and it is time for the *hasor* prayer. The community health worker returns to the shelter, and the mother-in-law tells her that they will call her if there are any complications. Tasfia's first child was born at the hospital, but she does not want to tell me why now she wants to give birth at home. Probably, the medical personnel criticised her early marriage and pregnancy, as I have already heard in another camp. At 2:30 p.m., we return to the delivery room, the mother-in-law stands behind the pregnant woman, one sister-in-law is in front of her and blows her breath air towards her to reduce her pain. The mother-in-law prays and repeats the word *bismillah* (i.e., in the name of Allah). Two women on Tasfia's side are sitting on the floor, and the one on the right uses a typical Rohingya fan for both Tasfia and her 4-month-old daughter next to her. Fatima explains that Tasfia is not yet feeling any pain, and the baby will not come out easily. The outside genitals are dry, and Fatima applies some vegetal oil. The ladies all discuss that Allah will take care of this... The woman in front of Tasfia is holding her feet, and while moving Tasfia's legs upward, she starts shaking them. Everybody tells her to stop, while Tasfia starts crying. The pregnant woman is not treated very well by the rest of the women around her, like her mother-in-law, sister-in-law, and neighbours, who keep telling her to hurry because I have to leave before 4 p.m. Once I tell them that there is no hurry, they tell me to shut up and that this is only an excuse to motivate the discouraged pregnant woman. The latter asks to speak to her

¹⁶⁰ Rohingyas commonly refer to Arakan, instead of Rakhine State.

husband. Her mother-in-law ignores her and starts saying that she needs to be brought to the hospital, probably just to frighten her. I have the impression that the pregnant woman, because of her young age, is mocked by the other women who consider her inexperienced.

Fatima tells Tasfia to get up and put her shoulder against a bamboo pillar: “Try to push with your back while squatting!” Tasfia’s mother-in-law stands before her and pushes her shoulder against the wall to help the young woman. Tasfia lies down again, and while two women hold her legs, she grabs Fatima’s ankles. Some women walk away. I am asked to hold one of her knees and place a hand on her stomach. It will still take some time until she starts pushing. Shortly before 4 p.m., the baby girl is born and starts crying, but the placenta remains inside. Three women thus push the lower part of her stomach: one woman first puts her hand into Tasfia’s mouth, then Tasfia’s hair to induce a sense of nausea and, therefore, pressure.¹⁶¹ Fatima uses her hand to pull the placenta out. She then cuts the cord after tightening it with two pieces of thread. She places the placenta in a plastic bag. Dihan and I are meant to go: We explain this to Fatima and tell her we will meet her tomorrow. Outside, it is raining heavily.

This homebirth’s temporal and spatial dimensions emerge through observing specific details that distinguish some actions from others. Artificial socio-cultural boundaries can be created in a continuous social realm through time and space (Leach, 1976). During Tasfia’s childbirth, Fatima and the mother-in-law play a leading role for two reasons. Fatima suggests what to do, whereas the mother-in-law takes the actual decisions. There are two timeframes at work informing this situation: A general one informed by recurrent rhythms as well as by biographical life spans, to which people refer – such as prayers, marriage, or getting pregnant, allowing them to identify moments of their lifetime. A specific timeframe refers to this particular birth event, and to the different actions accomplished before, during, and after birth. It also relates to relevant spaces and their divisions.

In other words, during the pre-birth phase of this event, my research assistant and I wait in the entrance room with other women from the family and the *dhoroni*. During the pre-birth phase, we move to the second room, the kitchen, where the birth will take place. This room appears to be more protected because there is no door to the outside or any window. There, all preparations for the moment of birth occur, thanks to the presence of a group of women and the *dhoroni*. The rhythm of childbirth is interrupted by the arrival of the

¹⁶¹ Having the pregnant woman to chew her own hair or some crushed onion to induce vomiting and facilitate the expulsion of the placenta is a common practice among Rohingyas.

community health worker, who tries to convince Tasfia to give birth in the hospital. Before her arrival, Fatima was moving freely from one room to another. Once the community health worker was also present, she tried to hide herself, both physically and in terms of her identity. The mother-in-law appears to be the decision-maker throughout, but Tasfia also acquires a crucial role in that she is the one who send the community health worker away. The prayer of *hasor* leads to the second phase, namely, the one approaching birth, which differs from the medical phases of birth.¹⁶² The institutions, such as the government of Bangladesh and NGOs, heeded home births with concerns for various reasons.

3. The Hospitals in the New Camp

I meet the camp-in-charge person (government administrator) of the new camp on my first visit there, and it seems that his interest is primarily in family planning policies. On this occasion, the camp-in-charge person tells me:

“NGOs do not care about family planning. For this reason, Rohingya women continue to have eight or nine children, and what about us? We are unable to take care of all of them! Their husbands do not care for their wives and are not good fathers.”

(Camp-in-charge person, personal communication, 29 May 2022)

The person in charge of the new camp blames the NGOs for the failure of family planning policies. NGOs seem to be less successful in implementing these programmes in the new camp than in the informal settlement camp.

In the same building as the camp-in-charge person's office, there is the site management office. Speaking with the NGO manager of the camp provides me with an overview of the camp's structure and services. In the new camp, there is a primary health centre and a health post; both are managed by Save the Children. Additionally, there is an IOM health post, whereas a third facility has been recently closed. The IOM and Save the Children health facilities both have maternity wards.

Talking to the Rohingya volunteers employed in the Save the Children primary health centre is challenging because the NGO requires that I obtain another permission, although the governmental RRRC office (Refugee Relief and Repatriation Commissioner) has already signed my request to conduct research in the camps and I informed the World health

¹⁶² As already mentioned in the Introduction of this PhD thesis, the three phases that I could observe during birth in the camps are different than the conventional medical ones.

Organisation (WHO) leading the health sector. Still, I visit the Save the Children primary health post and its large compound with various buildings corresponding to different sections.

I meet Haki, the supervisor of the midwives, who makes no distinction between “traditional birth attendants” and “community health workers”. She uses the related acronyms - “TBA” and “CHW” - interchangeably. She tells me that there are eight “CHW/TBA” employed at the primary health centre, and they are sent to people’s places to encourage them to use their facility for childbirth. “TBAs” (she insists on using this acronym) have been collaborating with Save the Children since April 2018. She clarifies that these individuals primarily work during deliveries, responsible for washing and facilitating communication between the pregnant women and the midwives. She adds that TBAs help organise sexual health awareness sessions for teenagers, persuade pregnant women to visit hospital, and participate in vaccination campaigns. She attempts to downsize my interest in traditional birth attendants by highlighting that Rohingyas are mere volunteers and very different from midwives. Rohingyas lack formal qualifications and are not permitted to intervene in emergencies, she underlines. Furthermore, they are not officially authorised to work in Bangladesh due to a lack of certification. Through her remarks, she points out two aspects. Firstly, birth attendants are less competent than midwives. Secondly, she fails to acknowledge the valuable role of traditional birth attendants in the humanitarian response.

Women who stay at home, the supervisor says, have many misconceptions about medicalised deliveries. They think that in the hospital they automatically get a Caesarean section and that the doctor is a man. She says that twenty-five women give birth at home, whereas 50 come to the hospital. I do not double check this figure immediately. However, in February 2022, a humanitarian worker employed in the domain of reproductive health told me that roughly 90% of women in the old camps gave birth in hospitals. On the contrary, in the new camps, this figure was almost inverted in that 80% of births occurred at home. This figure contradicts the midwife’s point of view on the rates of hospital and home birth in the new camp. Besides, Rohingya women in the new camp have just experienced the regulatory shift medicalising births and this might explain the fluctuating data on this issue. Instead, the rule has been in effect for more than ten years in the old camp.¹⁶³

¹⁶³ I have not official references of this policy, but Rohingyas in the old camp argue that home births have been forbidden since 2010-2012, as detailed in chapter 8.

On the way to the Arab country site,¹⁶⁴ there is the IOM health post that I decide to visit. There, another midwife, named Rachel, explains to me that antenatal and postnatal care services are available in the structure, as well as services in the domains of family planning and gender-based violence. The structure is open until 4 p.m. or 5 p.m.; otherwise, patients are referred to Save the Children, where they can stay overnight. The number of deliveries in a month ranges from one to five in the health facility, but there are around 130 pregnant women in the camp. She has a different opinion than the midwife supervisor, Haki, in the Save the Children primary health centre. In fact, she states that most women tend to give birth at home in this camp. Labour often begins at night, she explains, and since the primary health centre is far away, women prefer not to traverse this hilly area. Most of the patients are from the Arab site of the camp, but if the Save the Children health centre has many patients to treat, even Rohingyas from the other site attend the IOM health post. In both areas, women prefer giving birth at home as they fear that others might hear them scream, that a male doctor might see their body, and that the hospital is uncomfortable for them. A community of Chakma people resides in the camp area as well, and they could access the camp's services.¹⁶⁵ However, they do not visit the health post frequently.

Weeks later, I am allowed to talk to the Rohingya traditional birth attendants working for Save the Children, with whom I conduct a group discussion. I meet three women, and they tell me that their routine at the primary health centre consists of checking in at 8:30 a.m. and leaving the hospital at 9 a.m. to begin their visits in the blocks. Eight of them are usually in the field, whereas on Thursdays and Saturdays only four work in the camp. They return to the health facility at 2 p.m. and stay there until 3 p.m. They are available 24 hours a day and are responsible for informing women about antenatal and postnatal care services. They call for an ambulance if there is any issue concerning the mobility of pregnant women. Finally, they also have the duty to be present during deliveries. However, they are not allowed to intervene in it. I discover that two women are Rohingyas who used to work as *dhoroni* in Myanmar, whereas one is a স্থানীয়, *stanio*, a local woman who has been working as a volunteer for the hospital for four years. The three of them are sweating during our discussion, probably because they walked long distances in the sun, just before our

¹⁶⁴ As explained in chapter 5, the new camp is divided in the “town site” and the “Arab country site”. One site of the camp has been named after an Arab country that donated conspicuously to the Rohingya camps.

¹⁶⁵ In the village site there is a market, and this is used by both Rohingyas and Chakma people.

conversation. Considering the new working context for the *dhoroni*, it seems that these lost confidence in their positions and are divested of their original competencies.

“We are not doctors, and if a woman is giving birth at home and the child is not in good condition; if the woman is bleeding a lot; if she faints or is unconscious; if the placenta isn’t coming out; if she has complications in her abdomen, what can I do? Can we give her injections? No. We are not doctors. We are not saying that we shouldn’t assist a woman at all. We believe it is not good for a woman because, if she came here [to the hospital], she would get a lot of services and facilities, especially in critical conditions, while at home, if there is any problem, we can’t do anything.”

(Group discussion with community health workers in the new camp, 29 June 2022)

Rohingyas in the informal settlement camp consider the Research, Training and Management International (RTMI) hospital as a place to give birth, as a *dhoroni* is always present during their labour and delivery, and their family members can accompany them. In the Save the Children hospital in the new camp, some women seem to attend the health facility just to receive items as part of the “dignity kit”. The kit remains a tangible incentive to visit hospitals for many women, although receiving some gadgets would hardly restore their dignity. However, as soon as this distribution has stopped, their attendance also decreased. In general, women appear to be discouraged to visit the health centre due to the lack of support there.

Other Rohingya women need often to stay at home, given their limited mobility, as well as their role, responsibilities and nurturing tasks in their nuclear family. In their words, home births also reflect a gendered condition of restricted living and social exclusion affecting Rohingya women:

“Women don’t want to come here because they have many children; they have seven or eight children, and most of them are very young. If a woman comes here for six or seven days, the male figure [her husband] won’t be able to handle the child, who also wants to stay with her more than the father. That’s why they want to stay at home. Once, when women gave birth in the hospital, they used to receive many items: a mosquito net for the children, clothes, towels for the baby, soap, an umbrella...panties, and many other things. Now they don’t get these things, and they don’t come anymore.”

(Group discussion with community health workers in the new camp, 29 June 2022)

Furthermore, many feel uneasy living in a foreign country and prefer to stay home to deliver their children. Considering the Rohingyas' status as a persecuted minority in Myanmar completes the overall picture determining the high rate of home births, as the group emphasises:

"They are afraid because they are from another country! When you come from another country, you will be afraid of everything, as you do not know many things here. So, they are afraid. In Burma, there is almost no hospital, and the Rohingyas have to pay [if they go]. We are facing a lot of suffering in Burma! There is no hospital to go to, so women are afraid and prefer to give birth at home. Earlier, many didn't want to come to the hospital; now, more Rohingya women are coming. We convince them and explain to them the reasons for coming to the hospital."

(Group discussion with community health workers in the new camp, 29 June 2022)

Rohingya birth attendants are aware of all these motives that make births at home much more common in their camp, a survival strategy for many Rohingyas. Nevertheless, the institutional response in the health sector seems to discard Rohingyas' perspectives.

4. The Dhoroni's Registers of Knowledge to Assist Home Births

In the new camp, a community health worker or traditional birth attendant usually accompanies the pregnant woman to the hospital, where her female relatives are not allowed in the labour room. Besides, the new camp is isolated from the rest of the other camps, and it is rare for relatives to live in the same area. In other words, for women in this camp, there are often no female relatives who can accompany them to the hospital and therefore the *dhoroni's* role acquires crucial prominence.

Dhoroni Aicha comes from a village on the other side of the border that in Rohingya is referred to in two different ways.¹⁶⁶ She is between 40 and 50 years old.

In Myanmar, she received a United Nations High Commissioner for Refugees (UNHCR) booklet on how to accomplish home deliveries, especially relevant for cases of complications. If a girl is too short or too young or if a girl bleeds too much, then she should

¹⁶⁶ Many villages in Rakhine State have two names, one in Rohingya and the other in Burmese.

take her to hospital, as the booklet advises her. She speaks to me of a certificate that was burned in her house in Myanmar, certifying her participation in that training when she received the booklet. She was unable to access any other education in Myanmar, where she primarily learned from her own experience and her mother. She assisted her mother in giving birth to two of her brothers. Before she died, her mother told her: “Always be happy and don’t take any money for assisting any women. It is good work for a human.” Her paternal aunt was also a *dhoroni*; she learned from her after her mother’s death. She recalled her life in Burma well when she could move freely and engage in farming activities until tensions broke out. Her house was set on fire, and 18 people were killed before her eyes. She and her family tried to stay, but as the army was killing people everywhere, they took shelter around some hills and a forest area in Myanmar. One week later, they left after the army took the chairman of the village and his family and tortured them. They started their journey to Bangladesh:

“There was no food, no rice, no water, and on the road, there were many babies, pregnant women, and deliveries happening. While some babies died, others remained alive.”

(A., personal communication, 20 June 2022)

They continued to walk for ten days until they reached Whykong (Bangladesh), where they took shelter thanks to some villagers who provided them with food and water. Once in the new camp, Aicha worked for two years as a community health worker for a health facility, she went to every house to convince pregnant women to attend the monthly check-ups, take their weights, and check their babies’ pulse.

When I meet Aicha, she tells me that she has been fired as her hospital shut down after donations have been reduced. Other health facilities are looking for young community health workers who can walk long distances. Thus, Aicha has not found any other paid position. She has started again assisting pregnant women at home, checking the position of the baby and when they would be born. Furthermore, in case it is risky to give birth at home, she explains, she suggests that women go to the hospital. This is the case with her grandson, who was born in the hospital one month before our first meeting. Her son’s wife is 16 years old, and the baby weighed 2.5 kg at birth. So, as she explains:

“Since I am a *dhoroni*, I understood, called the ambulance, and she gave birth in the hospital.”

Several women in the new camp are afraid of attending the primary health centres, hence she continues assisting some of them at home. Rohingyas are accustomed to delivering their babies at home, and most of them prefer this option as they rarely have any experience in hospitals in Myanmar. Besides, they feel ashamed of the indecency of facility-based births, as women are easily undressed. For these reasons, they refuse to go despite many available instruments.

In this context, Aicha continues to perform deliveries at home, using her knowledge:

- She checks the baby’s position.
- She advises the pregnant woman to walk and do some exercises (if the pregnant woman does not walk sufficiently, it would not be easy for her to deliver; moving around would help her).
- After long waiting periods, when the pregnant woman feels hot, she advises her to lie down.
- She sits in front of her, asking her to pull her legs and push, using a rope that is tied to the ceiling, and being pulled by the woman.
- She uses her hand at the entrance of the pregnant woman’s vagina to exert downward pressure.
- The baby should, at best, come out by itself.

All those steps are always accomplished not because of her presence but, as she emphasises several times, according to Allah’s orders. The precision with which she describes these steps and her approach, however, recalls the NGO training she has attended. I am not surprised that, in her meticulous description of how to assist the pregnant woman in expelling the placenta, there is no mention of traditional practices, such as chewing her hair or some pieces of an onion. Still, she refers to the rope to pull and exert pressure, namely, the *rosi*. In case the placenta is not expelled, in fact,

- She would massage the belly of the woman.

- She would ask the mother to fold her legs (to avoid excessive bleeding) and to cough to assist the placenta in coming out.
- She would measure a four-finger distance from the baby's belly.
- She would tie two pieces of thread around the umbilical cord at a four-finger distance before cutting it.
- Then, she would place the placenta in a plastic bag so that the family could bury it.

In the camp, support from NGOs is described as almost non-existent for women at night, when Rohingyas have no choice but to give birth at home. As Aicha explains, at home, the rope is often broken, there is no helping woman present because they either sleep or are afraid of leaving their homes during the night, and the house might even lack a gas cylinder. In these conditions, she has to manage each delivery on her own without the help of other women. She adds, "It is safer for them to go to the hospital".

While one primary health centre forbade her to assist with deliveries at home, she still has faith in her role. Around March 2022, Aicha was told several times by Rohingyas working in the hospitals that she could face serious problems with her food rations if she continued performing home births. She said, "They threatened me. If I do it again, they will stop my rations and block my data card". The control over certificates, in this case, the data card,¹⁶⁷ appears to be a common way for authorities to punish Rohingyas.

¹⁶⁷ The data card is a sort of identity card for Rohingyas and is used to gain access in the camps to various services such as food distribution.



Image 34: A representation of the dhoroni Aicha, assisting a woman in giving birth at home during the night.

Still, Aicha smiles during our conversation, and she describes her everyday life in the camp as the simplest routine she can have:

“I wake up at *fojor*, I wash myself with the water collected the day before, go to the washroom, clean, say my prayers, read the Quran, cook something, send the children to the *moktob*,¹⁶⁸ and then I roam around. If I have to, I go to pick up some soap or medicines at the distribution points. I get rice monthly and a gas cylinder every 47 days. If there is any work, I go there. If there is any meeting, I go there. [...] There is no problem, but sometimes I need clothes, and if I want to go outside to someone’s house, I need new clothes, and I don’t have any. Sometimes I need an umbrella, but I don’t have any. Sometimes, I need a *balti*¹⁶⁹ or a pot, and I don’t have any. These kinds of problems I have, but they are no big deal.”

(A., personal communication, 20 June 2022)

¹⁶⁸ *Fojor/fozor* indicates the morning prayer. *Moktob* means kindergarten.

¹⁶⁹ *Balti* means bucket.

To foster women's decision to give birth in the medical facility, authorities appear to promote an unofficial policy in the new camp and put pressure on the *dhoroni* like Aicha to stop home deliveries, as well as deny birth certificates to Rohingya children born at home. Authorities use certificates like the data card or the birth certificate as a way to control Rohingyas. As Fatima, another *dhoroni* assisting women at home in the new camp, describes this rule:

"No, we don't face any problems. But now we hear that they might not get the birth certificate...After the delivery, after eight or nine days, when they [newborns] are vaccinated, they get the *tika* [i.e., vaccination] and then with that card, the *tika card*, they can apply for the birth certificate. But the mothers have to lie and say that the delivery took place in a real emergency, at night, or that the delivery happened accidentally and they could not manage to go [to the hospital]. Yesterday, a delivery took place in the ambulance, for example."

(F., personal communication, 27 September 2022)

Theoretically, *dhoroni* illicitly assist women's home births and Rohingya women protect the *dhoroni* by addressing birth at home as an "inevitable solution" or as a "survival strategy" instead of their choice.

Tasfia's giving birth demonstrates that the general situation in the camps is tense, as shown not only by the absence of interaction between the *dhoroni* Fatima and the national community health worker, who tries to convince Tasfia to attend the hospital. Fatima even hides herself due to her fear of getting in trouble. In the end, it is Tasfia who decides to stay at home. She refuses to follow the community health worker to the health facility of the new camp – managed by the IOM – and to explain me why. As the midwife at the IOM health post partly mentioned, Rohingyas like Tasfia fear discriminatory interactions with Bangladeshi health personnel. During their labour and delivery, in fact, Rohingyas cannot have any leading role in the hospital. Furthermore, in the case of an emergency or Caesarean operation, pregnant women fear being transferred from the health centre to a specialised hospital outside the camp. Fatima mentions this point to me for the first time:

"In this facility run by the NGO Save the Children, delivery is very comfortable, but if the delivery does not occur normally, women are referred to another facility [in Cox's Bazar, *Shodor* Hospital]. There, pregnant women do not receive much care and respect; that's why they avoid even the Save the Children hospital [...] if they can manage to do so at home secretly, then they do so."

(F., personal communication, 27 September 2022)

For this reason, Fatima continues to support Tasfia and other women in giving birth at home but ensures that her activities supporting women remain secret. The absence of an active role given to the Rohingya *dhoroni* during deliveries in the hospitals discourages women to give birth in the hospitalised context in the new camp.

5. Birth at Home: A Result of “Traditional Knowledge” and NGO Training

It is mid-June, and it is raining in the camp today. There, “the administrator of the camp wants to talk” to me, Ujani tells me. Ujani is a humanitarian worker in the camp’s site management office. I tell her I have a meeting with a *dhoroni*, so I will visit the camp-in-charge person before the camp’s closure. My research assistant Dihan and I walk to block D to meet Fatima at her place. After some time, another woman arrives, also looking for her: She needs help for her daughter-in-law, who is about nine months pregnant and has been in pain since last night. We follow Fatima to visit the pregnant woman, and at the threshold of her shelter are two men, the husband and the father-in-law, who leave as soon as we get there. Dihan and I sit on a UNHCR carpet on the floor in the first room (usually used as the main room in this and all other shelters I have visited) and wait with the mother-in-law and her other daughter-in-law.

Meanwhile, Fatima visits the pregnant woman in the other room. Her name is Jobaida. Jobaida is almost ready to give birth and agrees that we stay with her in the other room during her delivery. We arrive at around 10 a.m. and will leave at 2:30 p.m. Once we move to the other room, just next to the main room, I observe the advantage of bamboo sticks and tarpaulin walls, where kitchen utensils hang or are wedged between the sticks. Typically, this room is used for cooking or as a bedroom, but the people in the room and how they are sitting indicate something else. Except for Dihan and me, at least at the beginning, they are all there to support and assist in Jobaida’s childbirth.

The men have just returned but remain in the first room. Only the father-in-law approaches the delivery room once and stands on the threshold for a few minutes to hold his grandson. In this way, the other daughter-in-law (the wife of Jobaida’s brother-in-law) can help Jobaida tie up her hair and remove her earrings. Fatima, her sister, my research assistant, and I are there. Lastly, there is a group of women coming and going all the time, including members of the family and neighbours. They are all women. The youngest sister of Jobaida’s husband had her first period yesterday, feels close to the pregnant woman, and

is particularly supportive. Giving birth and getting the first period are crucial moments of change and mark a significant passage in a woman's life here. Present in the room are the mother-in-law, Jobaida's brother-in-law's wife, a neighbour who gave birth three months ago, and other women who stay so short that I do not know their roles.

The air in the room is cool because a window on the left side, at the same height as the floor, remains open all the time. Fatima explains that the moment of *zwar*, of high tide, is perfect for births, as her grandmother used to say. She gives Jobaida a betel quid. She says that this will help her push and press properly later on. Then she asks the mother-in-law for a new razor blade and some thread, which the husband or father-in-law manages.

Jobaida is 20 years old. She married three years ago. In 2019, she thus left her family in the Kutupalong area (her camp of origin) and, as is standard practice, moved to her husband's family shelter. Being considered too old to have her first child, she finally became pregnant. I hear all this from the other women during these four hours.

Meanwhile, they take care of the process without much excitement but with a sober routine, during which they seem to treat the pregnant woman, at least in my observer's perception, almost as an object. This may relate to their routine, which, to some extent, minimises empathy with the pregnant woman while concentrating on what needs to be done next. For this, my notes also tend to focus on some parts of Jobaida's body: at the beginning, Fatima pushes gently on her stomach and back; Jobaida's sister-in-law sits behind her and massages her back with her feet; once the foetal expulsion seems to begin, Jobaida's mother-in-law and a neighbour sitting on the floor next to her hold a foot to the side of her belly while her sister-in-law supports her back. At the same time, the group of women continues to talk among each other (and sometimes to Dihan and me), mainly in mildly low voices. The *adda*, namely, the conversation, orchestrates the next four hours while Jobaida's delivery process supplies the rhythm. They talk about the cooked food they need to warm up continuously to prevent rotting. They mention Allah, who is the only one deciding on the success or failure of the birth; they even mention other women and how their deliveries went. As they discuss these topics, some with a more negative connotation, the *dhoroni* occasionally intervenes with encouraging observations on the baby's status – such as the baby moving or breathing.

Fatima also describes some problematic situations in which she supported other pregnant women. She says, for instance, that walking is essential for pregnant women. She learned this from a doctor, she emphasises. Besides, she claims with a note of surprise that midwives always scream in the hospital during deliveries. While the *adda* continues, I gain

a clearer image of the hierarchy of medical knowledge inside the hospitals in the new setting of the camps and their perception among the Rohingyas, especially once the neighbour shares her story about another pregnant woman who said that she would rather have died than give birth in a hospital. Fatima's elder sister, Khadija, who sits on my left, adds with a note of irony:

“ Khadija: Are you going to tell all this to the doctor?

Valentina: No! I am interested in your sister's profession.

Khadija: Never get married, please! Also, giving birth is such a pain!”

She starts laughing. Then, she turns to the other side and continues praying for the pregnant woman as if chanting. Fatima asks for some tea or juice so that Jobaida has sufficient strength to push.

The *adda* continues, and the women in the room talk about other relatives, other pregnant women of the camp, and whether they should do a collective prayer, for Jobaida. Fatima responds immediately with her practical attitude, saying, “Now we need your hands, not your voices”. Some women keep praying, but only a few of them remain in the room as soon as the birth event begins. They include Fatima, her sister, and that very young mother who gave birth three months ago, my assistant, and me. Hence, Dihan and I need to help as well. I sit on the floor and follow Fatima's instructions by gently pushing my foot to the side of Jobaida's belly. The neighbour does the same on the right side; Dihan is behind her, holding her back while Fatima stays in front of her and repeats the words *tel tel tel*, “push push push”. To help herself, Jobaida pulls on the *rosi*, the piece of cloth hanging from the wall around the central supporting bamboo column. Other women arrive, but we keep our positions until the baby is born, an hour later. The mother-in-law covers Jobaida's abdomen and legs with a beautiful violet fabric, as Jobaida feels ashamed of having her intimate parts exposed. The expulsion of the baby lasts for one hour; Fatima helps to pull the baby out. The mother-in-law begins to cry, and there is a moment of extreme panic because the newborn is not crying. Once Fatima spills some drops of water on the newborn's face, she starts crying, and Jobaida's sister-in-law pushes with her foot on the pregnant woman's back in a sort of massage. Fatima gently massages the baby's tiny legs and uses the thread to tie around two parts of the umbilical cord. She cuts the cord after the two pieces of thread are tightly secured. Fatima takes the placenta and touches the baby's shoulder with it. She gives the newborn a gentle water shower, holding her by her feet to ensure her body's

alignment. All the other women, who return to the room once they hear the baby girl's voice, pray and thank Allah because now the baby is born.

The newborn is brought into the other room to meet the rest of the family. The young mother looks exhausted and is sitting tired in the main room, yet she is awake. The women arrange a fire beside her, so that her body may heal. Half an hour later, they bring the newborn to her side. We leave to meet briefly with the camp-in-charge person, but when we arrive, we discover he has already left. It is 3 p.m., and we are supposed to leave the camp.

The pre-birth phase, including contractions, is characterised by the presence of many women in the second room, whereas during the birth, only a few attendants are present. These two moments also correspond to a spatial sequence: during the pre-birth phase in the entrance room, only men are seated, and in the second room, women are present. During birth, a moment of transition and uncertainty between life and death, the division between the two rooms is clear-cut in terms of gender divisions. A few women are in the room where Jobaida gives birth. In the entrance room, both males and females are coming and going. All these are elements of a ritualised order serving medical and social purposes under threatening conditions. Many in both rooms welcome life once Jobaida's daughter is born. The temporal and spatial dimensions of a "transitional ritual" regarding Rohingya medical experiences, customs and traditions occur habitually at home.

From these ethnographic materials, Fatima's approach showcases an influence from the practices of NGOs and what she has learned in Myanmar. A doctor taught her that making pregnant women in labour walk will facilitate the process of giving birth. By contrast, organising a fire to support the woman's healing corresponds to an old practice. Home births among Rohingyas in the new camp are prevalent to cope with their condition of social exclusion in the domain of reproductive health.

6. Concluding Remarks

Tasfia's childbirth exemplifies the crucial role of arranging certain tools in the room of her shelter to support her delivery, as well as the presence of other women. Tasfia pulls the *rosi* and pushes her feet against two flat, heavy stones to exert better pressure and expel her newborn. She also uses a large bag of rice to lean her back against it. The *dhoroni*, Fatima suggests what she could do to feel better, and shares her knowledge to support Tasfia. Recurrent visits to the health centres of the camp illustrate the superficial understanding that NGOs have of Rohingyas' preferences and the existing hierarchies. For example,

“traditional birth attendants” are aware of the reasons why Rohingya women prefer to deliver at home. However, the personnel maintain a stereotypical view of Rohingyas without really consulting them. In this context, *dhoroni* like Aicha and Fatima hold particular importance. Despite Aicha’s training certificate being burned, brutal persecution and her dismissal as a community health worker in the camp, she continues to apply the teachings from her mother and NGO training to protect pregnant women. She meticulously follows learned procedures and expresses gratitude to Allah for her success. Despite feeling discouraged and facing threats that her food rations will be diminished if she continues to assist with home deliveries, she maintains deep faith in her role. She applies various registers of knowledge with great flexibility. Pregnant women keep giving birth at home, although Rohingya *dhoroni* who assist with home deliveries are technically violating camp rules. The importance of the women’s support network also emerges during Jobaida giving birth. Fatima’s expertise leads everybody in the room; she employs various forms of knowledge, encourages the pregnant woman to walk, and suggests using the rope and the healing properties of fire after the delivery. The delivery is portrayed as a significant event in the female sphere, accompanied by the pregnant mother’s transition to motherhood, thanks to the presence of the *dhoroni* and other women.

Various layers of social exclusion affect women in the new camp. The medical personnel not only discard the knowledge of the Rohingyas as “illiterate”, but also disregard pregnant women’s needs. In this scenario, Rohingya women showcase their persistence in navigating their condition of social exclusion through various strategies activated during child birth in their shelters of the new camp.

CHAPTER EIGHT This Must Be the Place. Giving Birth in the Old Camp

1. Introduction

The principle of “maternal safety” that NGOs promote today by medicalising births in the camps has been implemented differently throughout the years. This emerges clearly in the old camp. For instance, organisations like Médecins Sans Frontières (MSF), but also others like Save the Children, have included directly Rohingya birth attendants in their initial approach to promote safe births at home.

As the birth attendant Moriam recalls during an interview with me in the old camp:

“earlier MSF used to give us gloves...[we] used to do the job at people’s houses, not in hospitals. As *dhoroni*, we were given a pair of gloves, a blade, two strings, and a clean white cloth for childbirth. When we arrived at the house, we cleaned the house, used gloves, performed the procedure, cut the placenta [cord] with the boiled blade, and cleaned everything.”

(M., personal communication, 21 July 2022)

Moriam, a *dhoroni* of 50 to 60 years old, has attended a series of training sessions provided by NGOs in the camp over the last thirty years. Initially, she used to work for Médecins Sans Frontières, which asked her and other Rohingyas to assist women at home. Birth attendants received all the tools to operate in the shelters. In this way, she has collaborated with the hospital since her arrival in Bangladesh between 1991 and 1992.

At that time, there used to be one *dhoroni* per block who was paid by the hospital managed by Médecins Sans Frontières. However, the government has requested Médecins Sans Frontières to leave the camp because in the 1990s the NGO opposed the forced repatriations of the Rohingyas. Shortly after Médecins Sans Frontières’ departure, home deliveries have been banned in the old camp and Moriam has been collaborating with the primary health clinic on an informal basis. As a result, it has been a long time since Moriam received her last salary, probably around 2010 and 2012. Today, only two *dhoroni* are employed and paid as “traditional birth attendants” in the same health facility now managed by another NGO. The other *dhoroni* have continued assisting pregnant women in the primary health centre without receiving any pay.

Two Rohingya female SMS volunteers ¹⁷⁰ take part in our discussion. They highlight that registered refugees are strong. ¹⁷¹ They are the pillars of the refugee cause because the government has been unable to repatriate them or collect their fingerprints. So, even if Médecins Sans Frontières has left, they continue to raise their voices when something does not work. I still ask myself: how have Rohingya women adapted to the situation of medicalised births in this camp for so long?

This chapter investigates why the old camp has the highest rates of medicalised births compared to other camps. In the informal settlement camp, two birth attendants are employed in the primary health clinic, and female relatives are usually allowed to be present during delivery. There, the number of medicalised births has increased in the recent years, also due to the widespread presence of NGOs. In contrast, in the new camp, no Rohingya is allowed to assist pregnant women in the hospital. For this reason, most women give birth at home. In the old camp, I soon realise that several past moments have influenced the state of reproductive health. Social actors explain differently the reasons that have convinced pregnant women to go to the hospital and how Rohingya women have dealt with this general situation. The personnel in the hospital of the old camp argues that the quality of services contributes to the high rate of medicalised births. Instead, many Rohingyas describe medicalised births as an obligation and a rule that camp authorities introduced around 2010 or 2012. Ultimately, the implementation of reproductive policies in the old camp over the course of more than a decade has probably contributed the most to the high rate of medicalised births.

2. Institutional Perspectives: the Camp-in-Charge Officer and the Site Manager

The conversation with the camp-in-charge officer, who has worked in the old camp for three years, takes longer than I expected. Next to his office sits a man who coordinates the bureaucratic matters and has been working in the camp for twenty-eight years. I suspect he might be able to share much more crucial insights about the old camp than the officer himself. However, in the camps, I have learned that it is crucial to respect hierarchies, so I strive to follow the observed procedures.

¹⁷⁰ The majority of Rohingyas employed in the humanitarian response are site management sector volunteers, and SMS stands for site management support.

¹⁷¹ As explained in chapter 4, registered refugees are Rohingyas who live in the old camps.

As per the condition of the permission issued for me to conduct research in the camps, I am required to collect the signatures of camp-in-charge officers in each camp where I want to conduct fieldwork. So, here I am. On the wall of his office hangs a list of senior deputy assistants who have administered the camp since 1994. The camp-in-charge person catches my attention when he tells me that I do not need to spend a whole month asking questions in the camp because Rohingyas are uneducated people. He believes they cannot contribute to the study of anthropology. I ask him why, and he repeats his point: the Rohingyas are uneducated, they have been away from Myanmar for long time, and there they could not even attend school. Eventually, he signs my authorisation. Before I leave the office, he advises me to visit only certain blocks of the camp because the others are dangerous. He adds that I should never walk around the camp alone and should seek the support of the SMS volunteers who can also report to him all the activities I conduct. Under these circumstances (of a somewhat paternalistic pre-alert) I pursue my research in this camp.

My next stop today is at the site management office to collect another perspective on the old camp, and continue to respect the camp hierarchies. I also plan to ask if any Rohingya volunteer has time to walk with me through the blocks. The officer I meet there is very polite and takes some time to share with me his perspective on the camp and blocks. Unlike the previous officer, he does not mention any “dangerous” area in the camp. He has been working in the Rohingya response for four years and has worked in different camps. For the past nine months, he has been assigned to the old camp, and he has observed that refugees here are aware of everything. He notes that the inhabitants of this camp know how to fight for what they deserve because they have been here for thirty years. Since 2017, when mobility outside the camp area has been restricted for refugees, the old Rohingyas have become aggressive, he adds. Furthermore, the government wants them to study the Burmese curriculum in schools, but they prefer to study the Bangladeshi curriculum. As a result, most schools in this camp have remained closed since the COVID-19 pandemic.

As for humanitarian workers, he says, “we have lost our dignity here, even though we work for the refugees’ dignity”. I ask what he means by that, and he replies that if a humanitarian worker in the old camp is unable to provide an immediate solution to refugees’ problems, then refugees often start insulting them. Then, he almost corrects himself by emphasising that many refugees have lived for some time outside the camp area and are thus educated. I try to continue the conversation, although I realise that I am increasingly

disturbed by how often people in this camp attempt to convince me that Rohingyas are or are not educated. He continues, “if we nurture them, then they will shine.”

At the end of our conversation, he mentions that there are four hospitals in this camp. One is the Gonoshasthaya Kendra (GK).¹⁷² Hospital, where the maternity centre is managed by Research, Training and Management International (RTMI). The settings are similar to those of the informal settlement camp, and I decide to concentrate my research on this health facility, where I fulfil the requirements set for conducting research.

3. The Primary Health Centre and the *Dhoroni* Sufia

When I first visit the GK primary health centre, before the renovation of its structure, I visit the maternity centre. There is a waiting room, from which one can reach the antenatal care room and the postnatal care room. From the postnatal care room, one can access the delivery room, where the supervisor of the midwives and a foreign midwife are currently providing mentoring to a group of Bangladeshi midwives.

The mentoring session consists of two parts. First, a practical demonstration of some manoeuvres using a baby doll. Second, a video from *Global Health Media*.¹⁷³ The first part focuses on shoulder dystocia and the appropriate manoeuvre that midwives should perform to ensure that the baby’s shoulder is not obstructed by the mother’s pubic bone. The video illustrates this manoeuvre through real-life footage of similar cases.

During the video, the foreign midwife reassures the group of Bangladeshi midwives who look intimidated by the complexity of the procedure. She tells them that they should not worry too much, noting that such cases are rare among malnourished women.

Noticing that I am observing their interactions, the foreign midwife explains that these are young and often insecure midwives. She also tries to reassure Rohingya women who are frightened, for example, by the “side cut”. Clinically, she clarifies that this is referred to as an *episiotomy*,¹⁷⁴ she explains. She continues, one of the greatest challenges in these situations is that the baby’s head may be too large to pass through the cervix, posing risks if this happens without interventions. In some cases, she specifies, the midwife needs to perform a side cut to prevent severe perineal tearing and facilitate the expulsion of the baby’s head.

¹⁷² GK is a public charitable trust operating in the refugee camps.

¹⁷³ Global health media is a project that creates visual content in different languages about special pregnancy cases. See more at: <https://globalhealthmedia.org/>, last accessed on 29th December 2025.

¹⁷⁴ After the woman’s consent being asked, healthcare professional cuts the perineum and vaginal wall. In this way, there is more space for the baby to be born.

Once the mentoring is over, I have a conversation with the Bangladeshi supervisor of the midwives. She explains to me that either the husband, his mother, or the mother of the pregnant woman usually accompanies her during delivery. Alternatively, a “TBA” (traditional birth attendant) may sometimes be present, she explains to me. At their facility, two traditional birth attendants and fourteen community health workers (CHWs) ¹⁷⁵ are employed from the refugee population. Two community health workers are assigned per block to visit homes and provide information, counselling, and identify all the pregnant women in the camp. She specifies that these community health workers are not traditional birth attendants. The rest of the birth attendants usually addressed as *dhoroni* are not employed at the primary health centre.

Soon, I am able to meet two *dhoroni* who highlight the controversies of this system. I visit Sufia, who complains about me being late. She has been waiting for me, and her daughter did not even go to work at the mental support centre, managed by the NGO BRAC ¹⁷⁶ in another camp. I apologise for my delay, and we sit together with the site management support volunteers. Sufia slices a juicy mango for everyone and starts chatting with the volunteers. Two neighbours stand at the door, listening to us. Once they leave, Sufia’s daughter begins to share her struggles with infertility. She explains that her menstrual cycle is irregular, and her ovaries are too small for her to become pregnant. At the age of twenty-seven, she is still unmarried. She cries and seems desperate about her condition. I think that she bears additional pressure as the only earning member in her family. I try to provide some consolation by saying that I also have no children. I am not sure it helps, but we move on to discuss Sufia’s role at the hospital.

Sufia explains to me that two *dhoroni* are employed at the hospital, while six others support Rohingya women in the camp without being paid. Sometimes, she receives presents from the pregnant woman’s family, but otherwise she earns no money for her job. She accompanies pregnant women to the primary health centre, assists them before and after birth, and helps deliver their babies. She adds that the midwives at the hospital only take care of the baby and the mother if their family of origin is wealthy; otherwise, they leave her time and space to assist in the delivery.

Sufia’s role as an unemployed birth attendant contrasts against that of Bangladeshi midwives, who have been trained according to the official domestic midwifery curriculum. The difference lies not only in the fact that Sufia has no formal education, but also because

¹⁷⁵ The medical personnel employ acronyms most of the time, also for traditional birth attendants and community health workers.

¹⁷⁶ See footnote 8 for more information on BRAC.

of her attitude. Midwives tend to avoid additional responsibilities, and sometimes even seem to shy away from their tasks. On the contrary, Sufia and other *dhoroni* regularly take pregnant women to the hospital and even perform the deliveries while substituting for the Bangladeshi midwives. Sufia also shares with me a rumour. In case of emergencies, midwives refer pregnant women to health facilities outside the camp. On the contrary, *dhoroni* insist on not transferring pregnant women to the hospital outside the camp as they are more confident in delivering newborns:

“I normally check women in the first, second, and third months...If someone is in pain, I try to heal her. I give the proper position of the baby, and if I can see that the waters have broken or the canal is opening, then I refer her to the hospital. I go to the hospital with her, and the nurse [midwife] checks the pressure and prescribes other things. But after that, it is me delivering the baby in the hospital, and when everything is done, we just cut the cord.”

(S., personal communication, 6 July 2022)

Despite not being paid, Sufia expresses gratitude for her role as *dhoroni* in her community. She does not criticise the fact that the camp-in-charge person penalises women delivering at home. She insists that giving birth in the hospital is the best choice for Rohingyas, who were systematically excluded from this type of service in Myanmar. Importantly, her status of unemployment does not affect her opinion on her work. She is firmly convinced she has enough experience to assist women during labour and delivery:

“We rely on our experience; we rely on our brains. We didn’t get any education. We were trained by MSF and RTMI when we were in Dhumdumia ¹⁷⁷ [a Bangladeshi village]. We didn’t have a formal education, but in the hospital, there are nurses [midwives] who don’t have a good understanding or sufficient knowledge. They are educated but lack experience in this work. We used to deliver at home, simply taking the baby to the hospital to be weighed, but very recently, it began to... that deliveries take place in the hospital. Then, in the hospital, the nurses are very young, and they don’t have enough knowledge or experience. They just tell us, ‘*Khala* [auntie], call us when the baby is about to come out’, and we sit there waiting. Then, when the baby is about to come out, we bring the baby onto the mother’s chest, and then we call the nurses.”

¹⁷⁷ Dhumdumia is a village in Cox’s Bazar District, part of Teknaf province, near the international border with Myanmar.

(S., personal communication, 14 August 2022)

The *dhoroni* appear to possess the authority of an experienced “mother” even though not all of them are formally hired at the health facility of the old camp. Sufia is often addressed with the expression *khala*, which in the Quran and in Bangladesh (among Muslims) is the regular term for a mother’s sister or maternal aunt.¹⁷⁸ This classificatory kinship reference suggests familiarity and trust, positioning the *dhoroni* as a close person maternal relative outside the nuclear family. As a result, young and inexperienced midwives tended to leave the *dhoroni* to assist pregnant women, whereas more experienced midwives would allow the unemployed birth attendants to help when they were busy or no physician checked.

After the opening of the renovated structure of the GK hospital, I visit the primary health centre again. According to the doctor in charge, the majority of pregnant women attend the facility, driven by the quality and variety of services they offer. She barely considers Rohingya women’s perspectives and the policies implemented over the last decade. We meet her at the hospital, which currently operates in two structures due to ongoing construction work.

One of the best-equipped primary health centres in the area, my research assistant Umme Kulsum and I speak for one hour with the female doctor coordinating the maternity unit. In the sexual and reproductive health ward, financed as the clinic in the informal settlement camp by the RTMI and the United Nations Population Fund (UNFPA), several services are provided in this hospital of the old camp, such as antenatal care, blood and urine tests, standard delivery, treatment of complicated pregnancy cases, postnatal care, family planning for short-term interventions (like the use of condoms or the pill) and long-term ones (implants or the intrauterine device). Finally, the ward envisages the provision of the “gender-based violence” procedure that is activated in terms of medical treatment for “survivors” of sexual violence.

Fourteen community health workers regularly visit Rohingyas in the camp and organise weekly sessions targeting mainly adolescents. In these meetings, they address different topics, such as the risks for young pregnant mothers, breastfeeding, or dengue fever. Also, two other Rohingyas play the role of outreach workers in the facility. A Bangladeshi national is a health educator for teenage pregnant mothers. He bears the primary responsibility for prevention activities. Community health workers engage with

¹⁷⁸ Hindus address maternal aunt as *masī* (মাসী).

health issues and refer new patients to the structure, whereas two birth attendants work during facility-based deliveries either in the day or night shift.

According to the doctor, very few women give birth at home because of the services they offer here – including the *matrisheba*, an ambulance service that transports women from their shelters to the hospital and back. She acknowledges that some Rohingya women still deliver at home when the baby is born at night. Their choice is partly due to the absence of immediate support at night from female relatives or birth attendants. Besides, walking in the camp during nighttime is not considered safe. These concerns create significant barriers to seeking institutional care during nighttime emergencies. The doctor also addresses the rumours that in other camps new Rohingyas think that home delivery is a better option. “The community health workers in this old camp do a great job trying to fight this prejudice! In this camp, indeed, the rate of home births is almost non-existent”, she emphasises. She further highlights that they offer quality services as they comply with the World Health Organisation standards of a check-up every month and two examinations after the eighth month of pregnancy. Women are also supported during labour or postpartum with iron or vitamin dosages. The hospital provides the so-called “dignity kit” for the mother and baby, which includes a dress, shoes, clothes, a hat, a blanket, towels, and soap. For the physician, the Rohingyas giving birth at home are “illiterate people”, but luckily, from her perspective, the mindset is already changing in the new camps. Nonetheless, she laments that the combination of factors, such as their religious views, their exclusive trust in the *dhoroni*, and the fear of being treated by a male doctor, makes women hesitant to attend hospitals.

In this camp, she continues, seventy women come daily, and there are approximately eighty-five deliveries each month. She tells me with pride that the facility was opened in 2008, next to her place of origin, and she had the chance to join this facility two years ago. Since then, no pregnant woman has ever asked for her placenta after delivery, and the medical personnel have disposed of it in the waste disposal bin or a specific pit.

The doctor seems unaware of the impact that the humanitarian response has on refugees. She is correct in highlighting that Rohingyas dispose of the placenta (inclusive of the umbilical cord) in a different way now than they did before their displacement. Rohingyas used to bury the placenta in a হাঁড়ি, *harhi*, earthenware pot, which stands for protection and care. Within the camps, these items are not easily accessible. Therefore, many families use polythene bags to avoid the placenta getting contaminated and jeopardising the baby’s health or the mother’s fertility. Specifically, burying the placenta is based on the reason of warding off dogs or foxes that might eat it, but also protecting the baby and the mother

against evil spirits. Rohingyas can rarely find a spot to bury the placenta in the camps. In Myanmar, they used to bury it in the garden or the open fields. Many might have considered the disposal pit of the hospital as a good option due to the lack of space in the camp area.

179

In other words, Rohingyas in Bangladesh conduct birthing practices differently because of the conditions of the camp life. While certain birth practices still correspond to those previously observed back in Myanmar, others have changed. For instance, in the old camp Rohingyas do not bury the placenta anymore, since the medical personnel handle it. At the same time, as the doctor correctly mentions, when a woman starts having contractions at night, she is more likely to remain at home. This is primarily due to the *dhoroni* and female relatives who would rarely walk to the hospital, also for the risks of walking in the camp after dark. Ultimately, birth and related decisions are shaped by the constraints of displacement. Cultural practices have not disappeared, but adapted to the living conditions of the camps.

4. The Authority of the *Dhoroni* and the Role of Certificates

The majority of medicalised births in the old camp occur while a *dhoroni* and/or a female relative is present. The *dhoroni* who is not employed in the primary health centre plays a key role at least for three reasons. By acting as an intermediary with the medical personnel, she supports the pregnant woman to avoid direct interaction with the Bangladeshi midwives, who are considered inadequately trained and less competent. Language barriers between Rohingyas and Bangladeshi midwives can make communication difficult. The *dhoroni* also helps delay different tasks and reduce the time spent in the health facility. They are not paid and may ask for some money from the family of the new mother. In contrast, midwives refrain from asking extra money from the woman's family. Despite the difference in price, Rohingya women prefer to be followed during the delivery by the *dhoroni*. Despite their lack of formal employment, *dhoroni* are indispensable during hospital births.

The majority of midwives employed in the Rohingya humanitarian response are at an early stage of their careers, they come from other divisions of Bangladesh apart from Chittagong and are addressed as *boingas*.¹⁸⁰ The term *boinga* is generally used by Rohingyas to highlight a certain distance from these midwives, as they do not feel as close

¹⁷⁹ For more information on the burial practices see section 5 in chapter 10.

¹⁸⁰ The term *boinga* indicated all Bangladeshis living outside of Chittagong. For additional details on the use of the term, see chapter 4.

as with local Chittagonians. The distance is aggravated by the hesitation some midwives show in their work. Whilst most midwives may behave with rude manners during antenatal care check-ups by displaying rude manners and dismissively criticising the Rohingyas' physical condition and nurturing habits, this does not significantly affect Rohingya women during that phase of pregnancy. However, when it comes to the actual birth these tensions can disturb the pregnant woman. The midwives' diffidence in the camps and their shy temperament, as well as their neglect of Rohingyas' perspectives create an environment of discomfort for many Rohingya women. As a result, these women may feel hesitant to give birth in the presence of the medical personnel, fearing that any possible friction could compromise their delivery. This contributes to the preference for home births in other camps where women avoid these tensions.

Home births have not been allowed anymore for years in the old camp, and midwives have left space for action to the *dhoroni* who unpaid have assumed much of the responsibility for delivery. This exception is probably based on the fact that in the past, *dhoroni* played an active role in the health sector by receiving delivery instruments by NGOs to assist women to give birth at home. Today, despite being exploited, *dhoroni* continue to support pregnant women during their deliveries in the hospital, where they are allowed to perform certain tasks during delivery.

During interviews and informal talks, numerous *dhoroni* refer to a significant shift that took place between 2010 and 2012, a change that has discouraged home deliveries in favour of hospitalised births. However, no official document mentions this shift. This shift is in line with the global health policies medicalising births and promotes a more inclusive approach for community health workers, rather than birth attendants. The expulsion of MSF from the camp, and the increase in funding for the humanitarian response have contributed to the formal introduction of hospitalised births. Besides, institutions have withheld birth certificates for children born at home to ensure that the rule of hospitalised births is respected. Another explanation for this policy change can be found in the makeshift settlements that were established next to the old camps. These settlements have been formally acknowledged as camps since 2017. It is likely that the rule to institutionalise births in the old camps might have been implemented to distinguish, at least in part, between the "registered refugees" in the old camps and those in the newer settlements. As a result, only children born in the hospital automatically receive a birth certificate. Certificates are also important for the *dhoroni* to keep their role of authority in the hospital of the camp.

During their forced migration, many *dhoroni*'s have accomplished deliveries in the precarious and wild conditions of the jungle. This persistence has entitled them to "become enlisted" in a "TBA list" (traditional birth attendant list), compiled by the government of Bangladesh, likely occurred after home deliveries have been suspended. The inclusion in the birth attendant list allowed individuals like Sufia was to participate in training courses organised by the NGOs in the camp.

As illustrated in the next pages, image 35 shows a certificate (without date) confirming that Sufia completed the training on "Basic principles of Antenatal care and Hygienic delivery". From the conditions of the certificate, it appears to be issued at the beginning of the response in the 1990s (image 35). NGOs are central to *dhoroni*'s descriptions of their profession, and are often represented as the source of learning, second only to the mentoring provided by female relatives. Image 36 further supports Sufia's work as a "traditional birth attendant" for Save the Children between 1993 and 1997. Image 37 certifies her participation in a recent training on "HIV/AIDS prevention and awareness" in 2007. These certificates hold great value for Sufia and other *dhoroni* as they not only validate their past collaboration with NGOs and legitimise their informal roles in the health facility of the camp.



Image 35: "Basic principles of Antenatal care and Hygienic delivery" certificate.

Save the Children



TO WHOM IT MAY CONCERN

This is to certify that [redacted] W/O-Mr [redacted]
[redacted] hana - Buthidaung, District of Akyab, Mayanmar
worked with the Rohingya Refugee Relief Project of The Save the
Children Fund (UK) (an international children charity organization)
from 02.01.93 to 24.02.97 as a Traditional Birth Attendance (TBA).

Her job included mainly attending during births, counseling mothers
before and after births on basic mother & child health care issues, child
rearing and vaccination of children. Apart from this she was also
responsible to follow-up pregnant & lactating mothers & new borns. She
was provided with formal training to perform these duties.

During her work we found her very cooperative, hard working and
efficient. So far my knowledge go she was very honest, sincere and team
minded.

I wish her every success in life.


Project Manager
RRRP, SCF (UK)
[redacted] ox's Bazar

The Save the Children Fund (UK)
House 20 Road 16 (New)
Charmoudi RA P.O. Box 55
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Image 36: Reference letter confirming Sufia's work for Save the Children as "traditional birth attendant" between 1993 and 1997.



Image 37: “HIV/AIDS prevention and awareness” certificate.

5. The *Dhoroni* Moriam: Oscillating Between Deliveries at Home and in the Hospital

In the hospital, clear lines of differentiation between *dhoroni* and midwives are drawn. Midwives are exclusively Bangladeshi women who have attended a formal curriculum and are certified midwives, whereas the *dhoroni* are female Rohingyas who have never been able to access midwifery specialisation courses - because excluded in Myanmar. Therefore, despite their experience they are not officially considered “reliable” during deliveries.

The few *dhoroni* who are employed in the hospital face immense pressure. They know that as soon as they ask for a day off, there will be many others ready to replace them. Unemployed *dhoroni*, who have attended an NGO training, are also referred to as traditional birth attendants. In both cases, the traditional knowledge is almost never considered as relevant. The emphasis on the “traditional” character of their knowledge seems superficial to me because, in practice, other Rohingya women assign them an authoritative role. This

situation does not affect every *dhoroni* in the same way. Due to several factors, some are widely acknowledged in their role. This is the case of Moriam.

We leave Moriam's around 3 p.m. It has been challenging to talk to her for the last two hours because she is authoritative and has a dominant personality. She does not facilitate Umme Kulsum's translation work in that she ignores the fact that she is translating from Rohingya to English for me. Moriam does not answer my questions directly and refuses to be recorded, claiming that a woman's voice leads to unholy thoughts. Even if I repeatedly explain to her that I will be the only one who is going to listen to our conversation for research purposes, she refuses. Thus, I put my recorder away. I take notes and write down some of the sentences she said, as she agrees with this solution.

Moriam whispers to Umme that I am *bezati*, namely, I am not Muslim.¹⁸¹ "How do you know I am not?" I ask, trying unsuccessfully to imitate her intimidating attitude. "I am a professional," she says, "I can understand if a baby in the womb is alive or not. So, I am able to understand people."

Moriam, Umme and I are sitting on the floor while Moriam's daughter stands on the threshold to the other room of the two-room shelter, and Moriam's son is sitting outside on a plastic chair just in front of the door in one of the common very narrow paths dividing the refugees' shelters in the camp. He tries to interact with me in his good English, and he wants to make me feel comfortable by highlighting that his mother did not decline to be recorded because of my religious non-Muslim background.

Moriam continues to have an aggressive attitude, and she tells me and Umme (who is, in fact, a mother of a daughter): "How can you understand anything I tell you about deliveries? You don't even have children." Besides, she also attacks Roshida (the Rohingya site management support volunteer who is with us) because she earns money, whereas Moriam does not. Before asking her any further questions, I reflect on the fact that everyone in her position, after having lived in these conditions for over thirty years and having been exploited by the NGOs at the health facilities, would have the same frayed nerves. Overall, her availability to talk to me for hours is a visible sign of patience and cordiality towards an unmarried non-Muslim woman such as me.

I ask her how she learnt to deliver children. She learnt from her *dadi*, paternal grandmother, she says. Then, she almost corrects herself by specifying that children are conceived thanks to the Almighty. Due to her experience, she is now able to tell when to

¹⁸¹ *Be-zati* literally means non-race. The term *zati* sounds similar to the Bangladeshi word জাতি, *jati*, race or nation. Rohingya can be described as a group, i.e., *zati*, and *bezati* means those who do not belong to the group. Moriam initially thought that my research assistant, Umme, is a Rohingya.

expect a baby or in which month the pregnancy is. In particular, she explains to me that if she touches the baby from the mouth of the vagina, and the baby is younger than seven months, then it will “go back”, whereas if it is older, it will stay at the mouth of the vagina. This check, performed with plastic gloves, is done in the last months of pregnancy. She takes a scarf and places it on the floor to show us what she means. She indicates the part of the scarf that looks like the head and says that on the top of the head, there is a water bag that will slowly finish, and the baby will come out. Immediately, she puts the scarf aside because she feels shy that someone could look or listen to what we are discussing. Then, she adds: “If you had recorded these issues! It would not have been good at all!”

Since she starts to tell us about so many details of the woman’s body, her son leaves: During the foetus’s expulsion, the child’s nose or forehead might get stuck in the skin of the mother. For this reason, she passes her finger around the vagina before delivery. Furthermore, if the baby has open shoulders, she makes sure to bring its arms towards the baby’s chest. She adds that she takes time to perform deliveries because, as she reminds us, “if the child is born, it is only thanks to Allah. My duty is simply to wait.”

I ask her about practising her *dadī*’s knowledge in the hospital. She explains that, at the beginning the hospital had no rope for the women to push with. However, this is now finally available. She refers to the *rosi*, rope, anchored into the ceiling, used by pregnant Rohingyas to exert pressure and push better during labour. She is able to check and change the baby’s position, whereas “nurses” [midwives] “have no idea what they should do,” she says. Once, during a check, they even broke the water bag (i.e., the amniotic bag) of a pregnant woman. As a result, the woman had to go to Cox’s Bazar public hospital, where she received a Caesarean section. Moriam also explains that women in the old camp prefer to avoid Caesarean operations. Together with other unemployed *dhoroni*, she voiced this concern during a meeting with the camp-in-charge person. Rohingyas are even sceptical of the so-called “side operation” (i.e., episiotomy) causing infection and requiring something like 40 or more days to heal.

Our conversation has taken a good course. So, I keep asking questions about her role in the hospital. “We do everything,” she says, “and for example, we bind the belly with a cloth so that the woman’s vagina remains in the initial position without prolapsing.” She goes on to explain that she works at the hospital but does not get paid because the camp-in-charge person is jealous. “It is also because I am old,” she says.

“Volunteers get 8,500 takas ¹⁸² as salary. We do all the work and do not get anything! At the beginning, we used to get 300 takas, then 700 takas, but for four years, we haven’t received any salary! But what shall we do? We are human beings. Human beings are here for human beings. So, even though the government does not pay us, we do the work anyway!”

(M., personal communication, 26 July 2022)

As our conversation continues, I ask her about home deliveries, and she replies that she performs them every day. She says,

“Registered refugees cannot give birth at home because this is related to rations. ¹⁸³ There are four groups of refugees. The old refugees, who arrived 35 years ago, are called ‘*furān furān*’ [i.e., old old]. ¹⁸⁴ The ‘*birannoboi*’ [i.e., 92 in Bangladeshi] refugees are those who arrived in 1992, the 9th October ¹⁸⁵ refugees who now live in Shubbagan, ¹⁸⁶ close to Camp 26, and who arrived six years ago. Finally, the new refugees.”

(M., personal communication, 26 July 2022)

Among each of these groups, she explains that she has helped everyone to give birth under any circumstances. Moriam tells us that she also assists local women in delivering at home. At the hospital, her supervisor asks her about this work, and she speaks openly about it because she has nothing to lose, as she is not employed. We begin to discuss her role in more depth, and Moriam defines some terms for us:

“In Bangla *basha* [i.e., Bangladeshi language], you say ‘*ful*’ [i.e., flower], while the Rohingyas call the same ‘*jol*’ [i.e., water] to indicate the placenta.”

(M., personal communication, 26 July 2022)

At the end of each delivery, Moriam ensures that the woman’s vagina is clean to avoid infections, as some particles could still be inside. Moriam massages the woman’s abdomen

¹⁸² BDT 8,500 Bangladeshi taka corresponds to around € 66.

¹⁸³ In the old camps, when a woman gives birth at home, then the camp-in-charge person will not register her newborn child, who consequently will not receive any rations, as Moriam explains to me.

¹⁸⁴ Many Rohingya words resemble Bangladeshi terms with the sole exception that the “p” is substituted with a “f”. Hence, “*furān*” in Bangladeshi corresponds to পুরান, *purān*, old.

¹⁸⁵ 9th October refugees arrived in 2016. This designation refers to the attacks of 9th October 2016 launched against the border guard police in Maungdaw and Rathedaung in Rakhine State. The attacks led to an escalation of violence, leading at least 27,000 Rohingyas to leave (International Crisis Group, 2016, p. 10).

¹⁸⁶ I could not find this location.

to facilitate the placenta's expulsion. She uses a thread before cutting the umbilical cord at home, whereas in the hospital, a nurse clamps the umbilical cord. Then, the placenta is buried in a mud pot covered with a plastic bag, whereas in the hospital, it is thrown into the pit.

Moriam has been a prominent figure in my understanding of the backdrop of births and the role of Rohingya *dhoroni* in the camps, oscillating between the assistance of births at home and in the hospital. She contrasts the common victimising image of the refugee woman and, while defying me with her hostile attitude, reminds me of another Bangladeshi ধাই, *dhāi* (also spelt *daī*), birth attendant (Munira, 2012, p. 134), whom I met on the outskirts of Cox's Bazar. Both of them, despite their different origins, give me the same sense of strength and stability of a person who is rooted in the imminent presence of life. Moriam has participated in NGO training in the past, and for this, she is known at the primary health centre where she collaborates. Furthermore, she accompanies Rohingya women to give birth there, although she continues to assist women with home births. Either Rohingyas or local women are comforted and sustained by her experience, convictions, manners, and persistence.



Image 38: A drawing of the *dhoroni*, Moriam sitting in her living room.

6. Concluding Remarks

My research in the old camp reveals the change of discourses and policies in reproductive health and how Rohingya women have adapted to them over the years. During my research, registered refugees are often described by both refugees and humanitarian social actors as tenacious people. How have they approached the shift in reproductive policies? The *dhoroni* Moriam explains that in the past she collaborated with various organisations to assist with home births. Another *dhoroni* Sufia emphasises that Bangladeshi midwives' attitudes are different from hers. She takes on much more responsibility than the midwives to ensure that women receive treatment according to their wishes. She expresses frustration over her economic difficulties, as she earns no money but feels she must express gratitude as midwives allow her and other *dhoroni* to help with deliveries at the hospital. For Rohingyas in the health centre, being accompanied by *dhoroni* or another relative means everything. They feel comforted and supported both emotionally and technically. This compromise is feasible because *dhoroni* have worked for NGOs in the past to assist with home births. To prevent Rohingyas from the makeshift settlement from mingling with the registered old camp population, the practice of withholding birth certificates in case children are delivered at home may have been introduced between 2010 and 2012. *Dhoroni* Moriam stands out as a patient individual, having lived for 30 years in the camp and experienced exploitation by the hospital where she assists women but is not compensated like other Rohingyas. She underscores her commitment to voicing the concerns of Rohingya women, such as their desire for a rope in the hospital delivery room and their preference to avoid surgery. Despite being unpaid, she continues to carry out specific practices during delivery, including placenta expulsion and offering massage techniques with unwavering precision for everyone, both Rohingyas and local people.

In the old camp, pregnant women have adapted to the regulations, and most of them now give birth at the health facility. Meanwhile, *dhoroni*, aware of the exclusion they endure as they assist women in the health facilities without being officially paid, make sure to always accompany pregnant Rohingyas.

Conclusion of Part Two

Part two of this dissertation begins by highlighting that mobility, social ties and humanitarian aid are crucial resources for Rohingya women, despite the backdrop of the forced migration from Myanmar and the general social exclusion in Bangladesh.

In the informal settlement camp, NGOs are particularly present. The inclusion of Rohingya women in the hospital system has contributed to an increase in facility-based births, although Rohingyas' knowledge is considered second-rank. The situation in the new camp is different. The medical staff disregard the reasons why pregnant women do not attend the health facility, leading most Rohingyas to stay home and deliver with the support of a *dhoroni* and the persistence of other women. Despite being aware of their exclusion and the fact that they are not paid for their role, in the old camp many *dhoroni* ensure to accompany pregnant Rohingyas to health facilities and respect the rules.

This part of the dissertation highlights the importance of gathering ethnographic details to explore the diverse ways Rohingya women have to respond to the medicalisation of births in three different camps. In the first camp, Rohingya women are more mobile, but this increased mobility does not necessarily mean that they challenge the medicalisation of birth. Because *dhoroni* are generally employed in the health facility, pregnant women are more likely to give birth there. In the second camp, Rohingya women's mobility is more restricted. Because they are not part of the birthing process in the hospital, *dhoroni* move from shelter to shelter to assist with home deliveries, relying primarily on social ties within the camp and the help of other women. In the third camp, movement is also restricted, but some *dhoroni* keep assisting women at home in other camps and nearby villages because they are not employed in the hospital. In this camp, women generally adhere to the camp's regulation of hospitalised births but only if they are accompanied by a *dhoroni* for their deliveries.

Overall, the location and history of each camp, the duration of camp life for Rohingya women, and the role women play in reproductive health services all influence how they navigate their use of mobility, social ties, and humanitarian resources.

PART THREE. ROHINGYAS' WAYS TO NAVIGATE LABOUR AND
DELIVERY: AN ANALYSIS OF SURVIVAL STRATEGIES, FORCED
CHOICES, AND ADAPTATION.

CHAPTER NINE Rohingyas' Ways to Give Birth: An Analysis of Multiple Factors

1. Introduction: Rohingyas' Pregnancies and Births Within Their Forced Migration

Historical analysis has shown that Rohingyas have been persecuted in Myanmar, and they fled to Bangladesh in masses in different circumstances in 1948, 1959, 1978, 1991-1992, 2012 and 2016-2017 (see chapter 3). Moreover, Rohingyas have migrated to Bangladesh in smaller groups because, among other reasons, they had no access to the health system in Myanmar, but these movements have not been systematically monitored (Leider, 2020). Still, all Rohingyas share a collective experience of direct violence and persecution. In Rakhine State, they have experienced systemic discrimination and exclusion from fundamental rights and services, like access to education and hospitals. In other words, they have experienced discrimination in the medical setting as well.

As for the Rohingya women, their persecution in Myanmar is often described through experiences of rape. During the most recent episodes of persecution, the United Nations Human Rights Office of the High Commissioner (2017) documented instances of sexual violence and gang rape principally targeting Rohingya women in Rakhine State. According to the Bangladeshi Minister of Home Affairs, Asaduzzaman Khan, in 2017, 335,000 Rohingya women (90% of female individuals) experienced rape.¹⁸⁷ Besides, scholars have examined the persecution of Rohingya women with reference to rape (Anwary, 2022), rather than in relation to pregnancies.

Humanitarian sources have claimed that 30,000 pregnant women have left Myanmar (UNFPA, 2018), while the Bangladeshi Minister of Health and Family Welfare, Mohammad Nasim, has referred to 70,000 pregnant women (8.3% of the Rohingya female population).¹⁸⁸ ¹⁸⁹ Regardless of the accuracy of these numbers, what gains attention here is that the high number of pregnant and lactating women fleeing violence is a result of gender inequalities. In this scenario, the majority of Rohingya refugees in the camps are women.¹⁹⁰ They escaped not only because of "forced pregnancies" in a context of war, where the

¹⁸⁷ Bdnews, 2017.

¹⁸⁸ Daily Asian Age, 2017.

¹⁸⁹ According to scholar in international relations Susan Hutchinson (2018), data discrepancies are due to the emergency context (2). In such scenarios, she primarily relies upon governmental rather than humanitarian sources.

¹⁹⁰ 52% of women were registered in 2018 as living in the camps (ISCG, 2018, p. 13).

Myanmar military have used sexual violence as a “weapon of war” (Boesten, 2018, p. 465; Hutchinson, 2018, p. 6; Mookherjee, 2015), but also because of gender, political and ethnic discrimination. Many Rohingya women fled Rakhine State because they could not access medical services. Denying them medical care is an indirect form of persecution, especially in emergency cases. Despite a general decrease in the global maternal mortality rate of 50% over the last thirty years, it still remains high in countries like Myanmar, especially during ethnic conflict (Kernohan et al., 2018, p. 2).

In wartime, rape and sexual violence are considered strategies to divide communities that are based on the family’s unity (Boesten, 2018, p. 465). After being persecuted and forced to migrate elsewhere, like to the camps of Bangladesh, Rohingyas have tried to regain unity. However, the social exclusion that Rohingyas face primarily due to their legal status and political situation in Bangladesh challenges these attempts. At the beginning of the Rohingya humanitarian response in 2017, pregnant women did not gain access to quality antenatal care in the camps (Joarder et al., 2020). Because of their collective experience of Myanmar’s genocidal persecution and the camp life in Bangladesh, most Rohingyas prefer social ties in the form of “social capital” (Islam et al., 2022, pp. 4, 9). These collective experiences have inevitably led many Rohingyas in the camps to live in a state of fear and mistrust towards the available infrastructure in the camps, along with a general dissatisfaction with healthcare services (Islam et al., 2022, pp. 2, 20). Some initiatives have been launched to improve access to sexual, reproductive and maternal health services in the camps (Center for Reproductive Rights, 2024), but they remain biased. Moreover, the constantly changing rules in camps that restrict Rohingyas’ social ties and alliances dissuade Rohingyas from using humanitarian services.

To navigate these settings, which differ from camp to camp, Rohingya women pursue different strategies. They face a “forced choice” when they give birth in the hospitals of the informal settlement camp. They employ “survival strategies” at home and give birth in their shelters in the new camp, while in the old camp they have “adapted” to hospital births, a regulation in force for more than a decade. As a result of a precise analysis, outlined in part three of this thesis, the three ways serve Rohingyas to navigate the multiple discourses around reproductive health. The factors affecting births in the humanitarian context of three different camps in the geographical Global South have an impact on Rohingyas’ voices and fears in relation to labour and delivery.

2. The National Context, Family Planning and the Notion of Pollution

The narrative about midwifery, its timeline and role in Bangladesh, as well as in global health policies, are crucial factors to consider in my analysis. Bangladesh is often described as a successful example due to its sharp reduction of infant and maternal mortality rates over the last three decades (Arifeen et al., 2014). However, the main political target in the country has gravitated towards birth rates and overpopulation control (Larson & Mitra, 1992). Since the country's independence in 1971, contraception and family planning have been largely promoted (Akhter, 1992),¹⁹¹ and NGOs have played a prominent role in implementing these policies through facility-based births (Ferdous et al., 2021). Since the USAID intervention in 1972, moreover, family planning has been systematically implemented (Mookherjee, 2007, p. 345). A decade later, services for Maternal and Child Health were introduced by bypassing the *daī* (Rozario, 1998, p. 166). The role of *daī* (দাই “birth attendant”) becomes important here. Bangladeshi anthropologist Rozario describes the *daī* as an elderly, illiterate and widowed or divorced woman who occupies a lower social status.

For example, based on the *daī*'s uniformly “low status” (Rozario, 1998, p. 150), the International Centre for Diarrhoeal Disease Research (today known as icddr,b)¹⁹² has bypassed “traditional birth attendants” in its initiatives. It has looked for a compromise and, instead, employed “Female Village Workers” (Rozario, 1998, p. 166). Chosen for their younger age and better education, the female village workers have been employed as a mediating figure between pregnant women and medical personnel in health facilities. They are now called “Community Health Workers”. However, they rarely have any experience in delivering children since their main task is to persuade women to attend health facilities and they have to “educate” traditional birth attendants (Rozario, 1998, p. 167). While international organisations have changed their opinion on the matter throughout the years and have lately acknowledged that trained traditional birth attendants could have not reduced infant and maternal mortality if “poverty, illiteracy, and discrimination [...] are not addressed” (Rozario, 1998, p. 167), Bangladesh has not easily shifted its position on this

¹⁹¹ Before 1951, fertility among the peasantry in what is now Bangladesh was not controlled by any medical or administrative authorities. The young age of marriage and uncommon contraception practices led to a trend countering high mortality rates in the country. Hence, reproduction rates have increased at a moderate rate of 1% per year (van Schendel, 2009, p. 70). This situation initially reduced poverty by promoting additional household labour. Eventually, however, reproduction growth accelerated. From 23 million people as the resident population in 1972, this figure has multiplied more than sevenfold in the early 21st century (van Schendel, 2009, p. 71). Today, Bangladesh ranks among the ten most populous countries worldwide, and it is one of the most densely populated territories on the globe (van Schendel, 2009, p. 71). This aspect should be also factored in when analysing the domain of reproductive health.

¹⁹² The icddr,b is an international organisation based in Dhaka that engages in health research.

matter. In the 1990s, training programmes in Bangladesh started for just a few traditional birth attendants in each village, and these policies of inclusion were not particularly effective in the country (Pillsbury, 1990), especially because the work of NGOs aimed to medicalise births anyway (Rozario, 1998, p. 144) and in hospitals the role of birth attendants is not always appreciated. The introduction of a midwifery curriculum in 2013 and of the certified midwife sustained the medicalisation of births in Bangladesh (WHO, 2019), although “traditional birth attendants” continued to play a fundamental role in home births across urban and rural areas of southeastern Bangladesh, like Chittagong.

In the camps, the implementation of family planning programmes and their relevance primarily emerge in chapter 6. The way Bangladeshi medical personnel work in the informal settlement camp, as well as the critiques they direct towards the large Rohingya families, point to the relevance of family planning methods. Furthermore, chapters 6 and 7 highlight the tension between the divergent roles of community health workers and birth attendants. In the hospital of the informal settlement camp, fifteen community health workers are hired in comparison to the two traditional birth attendants. Medical personnel praise the former, whereas the traditional birth attendants are asked to accomplish humble tasks. In the new camp, younger Rohingyas are employed as community health workers, and *dhoroni* keep secretly assisting pregnant women in their shelters because no Rohingya can assist deliveries in the health facility.

In the context of Bangladesh, Rozario has argued that the critical approach of scholars towards the medicalisation of childbirth should be carefully extended to the Global South (Rozario, 1998). The academic struggle against the excessive medicalisation of births belongs to the “women in Western countries” (Rozario, 1998, p. 144). Her argument is sustained by the fact that medicalising births reduces mortality, and, therefore, its implementation is positively regarded in Bangladesh. Nevertheless, mortality in Bangladesh has also decreased because the birth rate has declined. In other words, mortality at birth decreased in the first few years following the implementation of family planning programmes and the overall decline in births, rather than due to the medicalisation of births. In fact, mortality levels have not recently declined further.

To understand this context thoroughly, it is crucial to address the notion of pollution. The work of Canadian anthropologist Thèrese Blanchet (1984) in Bangladesh has identified three levels of pollution: the first is connected to the hill tribal level and the pollution of women, seen as attracting spirits of nature, where the female and male unite. The second

and third levels are connected to religion. In Hinduism, the pollution of women is perceived as repelling Brahminised gods. Similarly, Hindu cultural values influence Muslims in rural Bangladesh, and women are excluded from *samaj* (i.e., the religious society). Overall, women might be perceived as a threat to the purity of rituals and unreliable in conveying Islamic principles (Blanchet, 1984, pp. 61, 62). In the 1990s, other ethnographies also described birth attendants in Bangladesh, known as *daī*, as “uneducated” women who do not ask for financial remuneration for their work (Blanchet, 1984; Gardner, 1991; Rozario, 1992, p. 161). In today’s Bangladesh, the *daī* occupies a low status, which has been explained through the notion of “pollution” that designates this profession, especially but not only among the minority of Hindu communities (Rozario, 1992, p. 169). Her status is related to the caste system, which is not the social system of reference for the Rohingyas.

During my fieldwork in the area of refugee camps and the surrounding villages of southern Chittagong, birth attendants are not perceived with such a negative attribute. Instead, their position in the community is connoted with a general attitude of quiet respect. This may or may not relate to the stronger presence of Muslim values among those refugee groups with whom I have worked because, obviously, the “impurity factor” related to birth is somewhat less accentuated in these Muslim contexts and has no explicit equivalent in Islamic values.

The notion of impurity is central in the volume *Homo Hierarchicus* by French anthropologist Louis Dumont (1966). According to Dumont, who studied the Hindu caste system, Hindu society is based on the binary opposition of “purity and impurity” (Dumont, 1966). As Blanchet points out, Hindu values have influenced Muslims in Bangladesh (Blanchet, 1984, p. 62), among which this opposition also gains relevance. Dumont has influenced the study of midwifery in South Asia by explaining birth as a moment of “temporal pollution”, whereas “permanent pollution” defines the role of certain individuals like the *daī* (Dumont, 1966, p. 71). Dumont’s dualist approach has been criticised by scholars who have explained South Asian society differently, like McKim Marriott (1990) who talks of an array of transactions generating the construction of hierarchies in South Asia. Besides, feminist and critical scholarship view the rules of purity and pollution as matters of domination (Cohn, 1987), which have been approached quite differently by the interdisciplinary tradition of *Subaltern Studies* (Guha, 1997; Spivak, 2010).

As highlighted in a series of studies on the Indian subcontinent, medical staff are usually not only hostile towards poor patients, but their treatment often depends on whether the patients participate in family planning programmes (Jeffery et al., 1989; Jullien, 2019).

In public hospitals, certain health workers even physically reject some patients because of their odour, religion and origin, looking at them with moral indignation and, due to the patient's socio-cultural "impurity", regarding their bodies with disgust (Jullien, 2019, pp. 211, 212). This attitude has been characterised as common in both Bangladeshi and Indian hospitals, where village people are often treated with arrogance and insulting behaviour (Jeffery et al., 1989, p. 110). In other words, it reflects issues of hierarchy.

The notion of pollution is not present in Claude Delachet-Guillon's (2000) ethnography on births in Myanmar. There, the birth attendant looks after the mother of the newborn and gives her massages to warm her up and re-establish her balance. Besides, the use of the fire and hot-brick fomentation are intended to reinvigorate the birthing mother and her body after delivery (Delachet-Guillon, 2000, pp. 40-42). Birth attendants in Myanmar and the *dhoroni* among the Rohingyas in the camps hold a well-respected position, contrasting with the *daī* in several areas of rural Bangladesh and India, as well as the overall attitude present in the hospital of the camps and among Bangladeshi medical personnel because the notion of pollution does not directly characterise their understanding of birth.

3. Global Health Policies and Their Implementation in the "Experimental Battlefield"

Another factor in the current analysis concerns global health policies and their implementation in the humanitarian context of refugee camps. This section begins by retracing the most relevant initiatives launched globally in the field of reproductive health. It will then discuss the relevant theories to examine how these policies play out in a humanitarian context that resembles an experimental battlefield.

The global discourses around midwifery share a similar yet distinct timeline when compared to Bangladesh. To gain a broad overview of recent global health policies in the domain of reproductive health, the *Safe Motherhood Initiative* of 1987 deserves first attention. Initially, it was launched to reduce maternal and infant mortality rates in the Global South. In the first ten years of this initiative, the policy provided training to "traditional birth attendants" to include them in the work of hospitals across the world.¹⁹³ However, a decade later, the global mortality rate at birth did not change and traditional birth attendants were regarded as "not effective" (MacDonald, 2022, p. 99). They were seen as the cause of this

¹⁹³ The World Health Organisation (WHO) defines a traditional birth attendant as "a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other traditional birth attendants" (WHO, 1979, p. 7).

failure due to their illiteracy, resistance to change and lack of credibility (MacDonald, 2022, pp. 99, 100). In 1997, a new initiative, *Safe Motherhood Agenda: Priorities for the Next Decade*, promoted the eventual abandonment of the training programmes for traditional birth attendants. Shortly afterwards, several anthropologists criticised the previous training programmes for birth attendants as too general, decontextualised and not implemented comprehensively (MacDonald, 2022, p. 104). The neoliberal turn towards “economising” maternal survival had already taken place through the medicalisation of births (MacDonald, 2022, p. 107), as well as through the inclusion of community health workers instead of traditional birth attendants.

In 2002, at the International Confederation of Midwives meeting in Vienna, a group of midwives from Canada, New Zealand and the United States insisted that childbirth should not be medicalised and that there should be no difference in treatment between traditional birth attendants and midwives as equally relevant in assisting childbirth (MacDonald, 2022, pp. 95, 108). In recent years, the *World Health Organisation guidelines* have showed that these critiques have been received at decisive levels (WHO, 2012), and “traditional birth attendants” have been re-included in global policies (MacDonald, 2022, p. 108).¹⁹⁴ In line with these changes, humanitarian social actors have adopted similar principles in refugee camps but have remained biased concerning *dhoroni*’s expertise. In other words, humanitarian organisations underestimated the role that *dhoroni* could play in the medicalisation of births among Rohingyas.

The medicalisation of births is often presented in humanitarian discourse exclusively as a question of saving lives, but many other factors come into play. The definition of *nuda vita*, “bare life”, as provided by the Italian philosopher Giorgio Agamben, has gained popularity in related academic debates to describe the state of refugees in camps and their exclusion from fundamental rights and resources. Authorities decide who is excluded by placing refugees in camps, outside society, and controlling their life there. The physician and French anthropologist Didier Fassin challenges Agamben’s notion of bare life, arguing that the aim of humanitarianism is not merely to control refugees’ lives, but also to alleviate

¹⁹⁴ To sum up, the most recent initiatives promoted in the domain of reproductive health are (1.) *The Safe Motherhood Initiative* - promoted by the World Bank, the World Health Organisation, the United Nations Population Funds and other organisations in 1987 (World Health Assembly, 1978) - (2.) *The Safe Motherhood Agenda: Priorities for the Next Decade* of 1997 (Inter-Agency Group for Safe Motherhood, 1997), and (3.) *The Making Pregnancy Safer* of 2000 (WHO, 2000).

their suffering (Fassin, 2010).¹⁹⁵ While recognising the power dynamics and contradictions within humanitarianism, the notion of “politics of life” serves to describe the humanitarian mission of reducing people’s suffering (Fassin, 2010). Furthermore, Fassin’s (2010) contribution examines the conjunction where humanitarianism meets global health policies. As already elucidated from Fassin’s perspective, humanitarian responses seek to reduce people’s suffering, and this view complements the Foucauldian definition of biopolitics. Humanitarianism values human life – in this case, by aiming to reduce maternal mortality at birth – whereas biopolitics regulates it (Fassin, 2010, p. 453), for example, through family planning. Both dynamics play a significant role in the implementation of reproductive health policies in the camps.

Pregnancy services are generally provided by NGOs, whose approach is shaped by both global health policies and the already existing hierarchies in Bangladeshi hospitals (Zaman, 2004). In other words, various interventions occur in refugee camps, resembling an “experimental battlefield” of the kind discussed by Didier Fassin. Both the “sacred life” of humanitarians and the “sacrificed life” of local people coexist in this experimental battlefield described by Fassin (2010, p. 501). Humanitarian intervention, characterised by a strong sense of morality, is the dominant approach for engaging with national or regional social issues in the geographical Global South. It directly affects life in the camps that become an “experimental battlefield”, where both recommendations of global health policies and certain procedures are tried out to be then implemented elsewhere in the country. A very similar approach to medicalised births used in the camps has been extended to the surrounding villages, as I observed during targeted visits to hospitals outside the camp area.

In the old camp, tracing the different “experiments” conducted over three decades is more straightforward than in the other two camps. In the 1990s, NGOs promoted safe home births among Rohingyas by including *dhoroni* in their strategies and providing them with the necessary tools; the approach was influenced by global health policies that supported refugees’ lifestyles and were financially affordable. Over the years, community health workers have replaced the *dhoroni* employed by NGOs as birth attendants, due to the shift towards hospitalised births and generally increased funding. Services for pregnant women started to be provided in hospitals, and births in the shelters were prohibited because they

¹⁹⁵ Didier Fassin (2010) highlights the controversy around the Italian philosopher’s position for two reasons. First, it is ethically unjust to strengthen the dominant perspective of the ruling party by simply denying a political life to those who, like refugees, are excluded. Second, several investigations show the presence of political life in the camps.

were considered a “dangerous choice” due to the hygienic conditions in the camps.¹⁹⁶ No official document has directly addressed this regulation shift, which medicalised births in the old camps around 2010 and 2012. However, certificates and Rohingyas’ stories have demonstrated that these experiments occurred around the same period when Médecins Sans Frontières was expelled from the camp (see chapter 8). Last but not least, the departure of Médecins Sans Frontières from the old camp has shed light on a third experiment. In 1998, the United Nations Population Fund (UNFPA) began providing contraceptive pills to reduce the birth rate in the camps, and in 2001, the government of Bangladesh suggested that sterilisation and abortion services could also be introduced and attempted to offer food to solicit women to adopt birth control methods (Feeny, 2001, p. 54). This past manoeuvre resembles current ongoing practices of NGOs offering snacks to convince Rohingyas to attend meetings, as described in chapter 6 and further analysed in chapter 10.

4. The Reports *Joint Response Plan* and the Humanitarian Rohingya Response

The official annual reports of the Rohingya humanitarian response are titled *Joint Response Plan*, and this section examines these documents thematically, in relation to the initiatives implemented in the field of reproductive health. The *Joint Response Plan* is the annual fundraising document for the Rohingya response in Bangladesh.¹⁹⁷ Two general points emerge from this analysis.¹⁹⁸ First, the most significant aim in the humanitarian response is to prioritise the medicalisation of births in the camps, but most of the time without the direct involvement of Rohingya birth attendants. The Rohingyas who are involved are usually employed in the health sector as community health workers and, although some of them used to be *dhoroni* back in Myanmar, their main task in the camp is to visit pregnant women in their block¹⁹⁹ to convince them to attend the health facility. They rarely have a role during deliveries. Second, the domain of reproductive health is one of the targets of the health sector in terms of providing “comprehensive and life-saving reproductive, maternal, neonatal and adolescent health care to reduce morbidity and mortality rates” (ISCG, 2018, p. 58).

¹⁹⁶ NGOs in the Rohingya refugee camps have recently started disagreeing with home births because of the hygienic conditions in the shelters and have depicted home births as a “dangerous choice”. It is no coincidence that Mary Douglas highlights in her book *Purity and Danger* the links between pollution and danger, and the fact that impurity characterises situations of disorder (Douglas, 1966).

¹⁹⁷ 2024 JPR, available at: <https://rohingyaresponse.org/project/2024-jrp/>, last accessed on 24th January 2025.

¹⁹⁸ This section analyses five reports: the 2018, 2019, 2020, 2021 and 2022 *Joint Response Plan*.

¹⁹⁹ Each camp is divided in five to seven blocks.

At the beginning of the response, the first report in 2018 mentions advocacy matters for stateless people. It pressures the government to register Rohingya stateless children born on its territory (ISCG, 2018, p. 37). The government has remained sceptical about registering newborn Rohingyas due to the fact that Bangladeshi children in Cox's Bazar district have not been registered consistently. Therefore, it stopped registering Rohingya newborns consistently until local citizens have an ID issued (ISCG, 2020, p. 58).²⁰⁰ Besides, the report in 2018 highlights the broader issue of recognising Rohingyas as refugees in Bangladesh. However, such interests soon shifted in the report of 2019. The 2018 report registered that, among both Rohingyas and local people, the rate of facility-based births was below 5% (ISCG, 2018, p. 58). Probably for this reason, the 2019 report focused on a different approach: policymaking to reduce people's suffering and mortality at births through hospitalisation. One of the indicators to measure the goal of the medicalisation of births is the percentage of deliveries in health facilities. Furthermore, the *Maternal and Perinatal Mortality Surveillance and Response* system has been operating since 2019 to monitor and reduce mortality at birth (UNFPA, 2022b, p. 6).²⁰¹ Humanitarian social actors are beginning in this way to move their focus from advocacy issues about registration at birth to global health principles and medicalised births.

In the 2019 and 2022 reports, the health sector set one of its goals to improve the "health seeking behaviour and utilisation of essential service package among refugees and host population" (ISCG, 2019, p. 78) reflecting the will to "civilise and educate" people in the camps. To achieve this goal, the indicators have been described as follows: the number of trained community health workers and the group sessions to inform the population about the health services available in the camp, as well as the "percentage of women who had at least four antenatal care visits by the time of delivery" (ISCG, 2021a, p. 4). So, the role of community health workers acquires prominence in the medical context, especially in comparison to that of "birth attendants".

A report drafted by Translators without Borders²⁰² has highlighted that Rohingya women express concerns about being alone and not with family members while visiting

²⁰⁰ Rohingya birth registration has been established as an official procedure, as mentioned in the 2020 report.

²⁰¹ In 2022, 83 maternal deaths were reported in the *Maternal and Perinatal Mortality Surveillance and Response* system. Of these, 44% were due to haemorrhage (UNFPA, 2022b, p. 6). 80% of maternal deaths occurred in health facilities due to "delays at the community level", which referred to the pregnant women arriving late also given their initial preference for home births (UNFPA, 2022a, p. 5).

²⁰² Translators without Borders is a community that connects translators with nonprofit organisations. In 2011, it was incorporated as an American nonprofit organisation that reduces linguistic gaps in humanitarian responses across the world. In 2021, Translators without Borders created a new organisation "CLEAR Global" (see more at: <https://translatorswithoutborders.org/about-us/>).

hospitals (Translators without Borders, 2021, pp. 2, 6). Therefore, the figure of community health workers has been introduced to fill this gap. Their support has enabled many pregnant women to establish trusting relationships with healthcare facilities through facility-based check-ups throughout their pregnancies (Translators without Borders, 2021, pp. 2, 6). However, some community health workers are not allowed in the delivery room, and some health facilities in the camps are still not easily accessible to many women. In these cases, Rohingyas prefer to deliver their children in their shelters, especially given their past experience of birth in their country of origin, where they were not allowed to visit hospitals.

The 2020 *Joint Response Plan* focuses on the collaboration between the sexual and reproductive health sub-sector (part of the health sector) and the nutrition sector. A joint training programme for midwives, community health workers and traditional birth attendants has been launched to implement certain lactation practices in the antenatal care centres (ISCG, 2020, pp. 75, 76). Nevertheless, the report provides no details about these activities.

The 2021 *Joint Response Plan* refers to pregnancy only in relation to the activities of the nutrition sector (whilst pregnancy is not even mentioned in the section on the health sector) and the objective of ensuring that pregnant and lactating women access nutrition services (ISCG, 2021, p. 35). However, the focus on birth of the nutritional sector was soon abandoned, as more recent reports do not mention such initiatives anymore. By analysing the reports with a specific focus on birth, birth attendants, pregnant women, antenatal and postnatal care, this section has revealed that there has been a marked increase in humanitarian interest in hospitalised births.

During my fieldwork, the medicalisation of births was enforced in the new camps. My fieldnotes often describe this enforcement alongside common narratives of national stakeholders, lamenting the numerous pregnancies that Rohingyas experience. Moreover, some of the medical staff in the camp hospitals frequently resort to this narrative to justify their discriminatory behaviour against Rohingyas. Narratives and prejudices are common among humanitarians who, regardless of the sector they work in, ²⁰³ describe Rohingyas as

²⁰³ On the explanation of the Rohingya response according to its division in sectors, see footnotes 9 and 22.

“irresponsible and uncivilised”.²⁰⁴ Moreover, births are associated with a notion of pollution, behind which exclusionary discourses are often hidden. The point of view of humanitarians is interesting because it often aligns with the general opinion of many Bangladeshis, influenced by family planning policies and the belief that overpopulation hinders economic growth. Bangladesh has implemented family planning policies since its independence and prioritised them in refugee camps. These narratives characterise the dominant attitude towards Rohingyas in the camps because international workers rarely work in the camps, and most humanitarian workers are from Bangladesh.

In the reproductive health sector, the World Health Organisation’s most recent policy to include birth attendants in the health facilities has not found any systematic foothold in the camps in favour of the Rohingyas. Furthermore, staff in the camp hospitals tend to influence Rohingyas and their decision to give birth at an early age – for instance, 12 to 13 years old (Melnikas et al., 2020, p. 9) – without considering the reasons behind such life choices. Since 2017, the number of births among Rohingyas has risen (Tripura, 2022, p. 5), probably because they are kept segregated from the rest of society (Jeffery & Jeffery, 2005). Life in refugee camps contributes to the rise in child marriages after puberty (Melnikas et al., 2020), and also because in Myanmar Rohingyas are not allowed to marry before the age of eighteen. These facts often constitute a point of friction with healthcare professionals in medical facilities, who disregard what marriage means for many Rohingyas living in extreme poverty conditions. Marriage functions as a means to reinforce ties and alliances. Births lead to larger families and, subsequently, more resources. Pregnant women who do not attend the hospital also actively avoid the criticism they often receive from midwives, nurses and physicians in the health facility on these matters. To conclude my analysis in this chapter, a final section based on my fieldnotes and literature on refugee camps will delve into the perspectives of some Rohingyas and examine the various rules within the camps that directly affect them.

²⁰⁴ Bangladeshi nationals working in the nutrition sector criticised Rohingyas who give commercial milk to their newborns. When looking at breastfeeding practices in the literature on migrants from Myanmar, almost opposite habits in the field of childbirth are mentioned than those criticised by humanitarian workers. For example, a study among refugees from Myanmar and Vietnam living in Australia demonstrates that the bodily state after childbirth supports women from Myanmar to breastfeed their children due to certain beliefs on the nature of breastmilk and the importance of recovery (June et al., 2020). Maternal milk is seen as “changing” according to the needs of the child, and the maternal body is perceived as a filter that purifies breast milk (June et al., 2020, p. 1174).

5. Field Study: Rohingyas' Voices on Childbirth in the Shifting Rules of the Camps

The analysis in this chapter has progressed on a theoretical level on the basis of reports, ethnographies and theoretical contributions. Analysing the reality on the ground proves more complex. Besides, camp life entails various shifting rules that have an impact on Rohingyas. The notions of “multiple laws” or “legal pluralism” may embrace the various dimensions contributing to the Rohingyas' social exclusion (Benda-Beckmann & Benda-Beckmann, 2013). One aspect of Rohingyas' social exclusion involves the humanitarian system attempting to control refugees (while alleviating their suffering) without recognising an important layer: the informal resources activated on the ground, like social ties with other Rohingyas outside or inside the camp area (Harrell-Bond, 1986). Humanitarian social actors introduce new social dynamics by employing Rohingyas in the response and establish a social order in the camps where there is no equal structure (Bornstein & Redfield, 2011; Fassin, 2011), since some Rohingyas may access resources that NGOs do not consider. To better understand these reflections, the story of Rubina can be helpful, along with references to earlier chapters of part two.

Rubina needs several hours from the camp to Cox's Bazar before travelling with me and my research assistant to her daughter. In other words, it is not easy for her to go outside the camp area. She must first wait at the camp hospital for her supervisor so that she does not have to take a day off, thereby risking her job as a community health worker. Many Rohingyas yearn for her position in the primary health centre. Therefore, she never requests holidays for fear of losing her job. When Rubina arrives in Cox's Bazar, my research assistant Umme and I leave with her by CNG ²⁰⁵ and reach her daughter's home at 1:30 p.m. Rubina's daughter offers us fruit and drinks. She insists that we have lunch with her later. It is very hot, and her sister-in-law also in the house tells us that she gave birth a month ago at a private hospital in the area known as the “*diabetes hospital*”, close to Cox's Bazar.

Initially, the baby had heart problems and was admitted to Cox's Bazar public hospital. Soon, the doctor requested that she pay BDT 3,000-4,000. ²⁰⁶ She did not have the money, so she went to another hospital where she was charged significantly less in exchange for medical assistance with the delivery. The hospital was privately run. In the private clinic, doctors were less careful with her health than at the public hospital, but at least they have a fixed price list.

²⁰⁵ CNG is a vehicle. For more details, see footnotes 32 or 222.

²⁰⁶ BDT 3,000 to 4,000 correspond to €20-30.

I believe it was Rubina who suggested that the sister-in-law give birth at a private health facility, especially since she works in this field. She knows that many Rohingya women fear attending public hospitals outside the camp and prefer to give birth at home or in private clinics. I think of Roshida's son, who died from brain cancer. Like him, many other Rohingyas prefer to be treated in private clinics. There, the likelihood of being treated respectfully is much higher than in public hospitals. For this reason, most Rohingyas attend private hospitals when they need to give birth or seek treatment outside the camps.

At least three key points can be highlighted from this encounter. Chapter 5 begins with Rubina's story. When Rubina was a child, her father decided to move from Myanmar to a village in Bangladesh where he made his fortune. Recently, he has moved to the camp in order to access more services. Rubina has moved separately with her own family as an adult to the informal settlement, which was officially recognised as a camp in 2017. Still, many of her relatives prefer to remain outside the camps. As part of her supportive social ties, they regularly meet with Rubina, and I join them on several occasions, like when we visit her daughter. Therefore, in addition to her role as a community health worker at the hospital, for which she receives a monthly stipend and is mobile within her block, she is also able to go outside the camp and meet her relatives residing in a nearby village, who provide her with additional support. In other words, she has various resources available that depend on her age, the number of years she has lived in Bangladesh, her role within the humanitarian response, and her social ties inside and outside the camp. However, Rohingyas involved in the humanitarian response need to work efficiently, as a general atmosphere of hesitation exists among humanitarians to employ the older generation of Rohingyas. In Rubina's specific case, she feels anxious about losing her job because she is aware of her "privileged" position as a community health worker, also gained through her linguistic skills in the local dialect acquired during her years living in a village. As described in the ethnographic chapter on the informal settlement camp, chapter 6, the older generation of Rohingyas is usually not employed in the humanitarian response, and camp life is challenging for those who have no regular income but rely mainly on humanitarian assistance. Chapter 7 demonstrates that, after being fired from her role as a community health worker in the new camp, Aicha struggles to secure paid employment between the ages of 40 and 50. In the old camp, authorities hire younger Rohingyas as community health workers, while Rohingya birth attendants assist with deliveries in the hospital without being paid. Such an informal agreement between the *dhoroni* and the health facility in the old camp

is based on other resources, the trust that Rohingyas have established since the 1990s with local people and NGOs. As explained in chapter 5, the old Rohingyas have established social ties with local people because they have lived in the camp for more than thirty years. Moreover, *dhoroni* had collaborated for at least a decade with NGOs to assist women with deliveries in their shelters until births were medicalised, and nowadays they continue assisting deliveries at the hospital even though they are not formally employed in the health sector. Hence, older women are more likely to be excluded from formal employment in the health sector.

A second point emerging from Rubina's story concerns the general rules of the camps enforced by NGOs; a regime of control over the physical integrity of Rohingyas, including pregnant women. For example, the data card (as shown in chapter 6) is mandatory to access camp services, and authorities frequently use this and other documents as a tool of intimidation. This has been the experience of many pregnant women who have to give birth at the camp health facilities to ensure that their children receive their cards and, therefore, food rations. In principle, they are not able to choose – like women living outside camps – to give birth at home or in a private or public hospital because their resources might be otherwise compromised. However, as explained in chapter 6, mistakes in the camp area can occur and result in severe consequences for people like Roshida. Since her son's death and her daughter-in-law's subsequent departure to the island of Bhashan Char, Roshida has not received any food rations for months because authorities believed she had resettled with the rest of her family on the island.

The encounter with Rubina, her daughter and her sister-in-law who gives birth in a private clinic sheds light on a third point. In the realm of reproductive health, refugees are generally expected to visit camp health facilities regularly. Most Bangladeshi midwives and physicians do not assume major responsibilities at camp health centres, and pregnant women in emergencies are referred to specialised health facilities outside the camps. Considering the abuses faced by Rohingyas outside camps, this approach completely ignores women's fears of public hospitals and the reasons behind their preference for private clinics. This rule is also unfair because it fails to recognise many factors. To begin with, it ignores the fact that Rohingyas have been persecuted for decades, are used to being deprived of services, and are resourceful in finding new solutions and ways to adapt. Furthermore, this rule requires pregnant women to visit a health facility outside the camp area, which not only involves confronting hostile Bangladeshi medical personnel, but also doing something that has been forbidden for years in Myanmar.

Two further reflections are warranted here, relating to the first point on Rubina's resources and the employment dynamics within the humanitarian system in the camps. NGOs employ Rohingyas as mere "volunteers" because, as clarified in chapter 4, without legal status, Rohingyas are not entitled to work, and their situation is aggravated due to the limited legal assistance available in the camps. This introduces a second perspective on "law" that is rather conventional and pertains to human rights (Verdirame & Harrell-Bond, 2005). Verdirame and Harrell-Bond (2005) highlight that bureaucratic factors might impact refugees' right to work. Even if refugees are legally recognised and permitted to work, they still tend to earn less than local communities (Verdirame & Harrell-Bond, 2005, p. 217). In Bangladesh, humanitarian social actors recruit refugees as volunteers, which violates human rights, as refugees are never officially employed. Furthermore, their incentives as volunteers are ethically unsound compared to the salaries of the international workers of UNHCR and other NGOs (Verdirame & Harrell-Bond, 2005, p. 221). Nevertheless, Rohingyas often perceive their role as paid "volunteers", whether as "birth attendants" or "community health workers", as either a reward or a new position within the community, especially after their forced migration and attempts to regain a place in Bangladesh within relevant social and economic support systems. So, even though such dynamics might seem critical from a human rights perspective, they could prove to be essential for people on the ground. For instance, chapter 8 describes how, in the old camp, *dhoroni* like Moriam continue working for other pregnant women without pay and are essentially exploited. Meanwhile, in the informal settlement camp, refugees like Rubina have embraced the cause of medicalised births to support NGOs. Instead, old refugees support the humanitarian system in a different way. They collaborate with the hospital because maintaining this informal and unpaid role remains a resource for them. Moreover, NGOs have supported them for over thirty years, especially when the government of Bangladesh attempted to repatriate them in the 1990s or to carry out forced sterilisations. Instead of trusting NGOs directly, old Rohingyas prefer to rely on how camp life functions. Nevertheless, the old Rohingyas are aware that the *dhoroni*'s work is unpaid, which causes tensions between them and younger Rohingyas who are more likely to be employed as volunteers in various sectors.

This reflection on respecting human rights and the creativity of refugees in coping with difficult circumstances leads to another important discussion. Some scholars argue that involving women in humanitarian programmes would enhance agency and allow them to develop a certain level of responsibility towards their communities (Guhathakurta, 2017, p.

644), as seen in the case of Rubina. Conversely, other scholars do not share this perspective and focus on community strategies, such as births in the shelters of the new camp that are presented in chapter 7. For instance, Rahman focuses on the practice of *talim*, the religious gatherings of Rohingya women who perform supplementary prayers in their shelters (Rahman, 2021). She criticises the NGOs' "women-only spaces", which do not allow women to feel comfortable in such formal settings (Rahman, 2021, p. 887), although some scholars view these spaces as fundamental (Wahra, 1994). Rahman observes women's everyday strategies in the practice of *talim* and regular meetings in their shelters to pray together, fostering a sense of belonging and giving new meaning to the anonymous dwellings of the camp. Sharing this singular moment of religious practice together is a way to express their past and present suffering with the awareness that everyone is in the same condition of displacement. Similarly, giving birth in their shelters with the support of the *dhoroni*, female relatives and neighbours restores unity within the "accidental community" of the new camp, as described in chapter 5.

These recurrent dynamics can be observed in the camps and are considered normal and normative, influencing how (1) *dhoroni* are included or excluded from the humanitarian response, especially based on their age; (2) Rohingyas are regulated through certificates and access to humanitarian resources if they do not adhere to certain rules (like the one regarding hospitalised births), and (3) pregnant women decide about the place of birth (whether at the hospital or in their shelter), while also bearing in mind that in an emergency they might be transferred outside of the camp area. Interventions in reproductive health often appear to be detached from the realities in the camps and the needs of the people, although they are implemented by "experts" and are in line with assumptions about Rohingya women and their families.

Academic literature on refugees should not be confined to official reports from humanitarian organisations that are significant (like the *Joint Response Plan*) but overlook the social dynamics among refugees (Harrell-Bond, 1986, p. 365), ignore local practices and do not thoroughly consider refugees' direct experiences. While some reports from international organisations may be accurate and useful,²⁰⁷ they tend to overlook the fact that the humanitarian system functions as a means of control and introduces new social dynamics of power that require analysis. Multiple rules govern the hierarchy of refugee camps, and the concept of legal pluralism includes these various layers of exclusion that

²⁰⁷ For a quality compendium on national laws and policies in Bangladesh see BLAST & Refugee Solidarity Network, 2021.

depend on different factors and resources. Scholars focusing on pregnancy in refugee camps call for an intersectional approach (Salisbury et al., 2016; Scott & Wallis, 2021; Urindwanayo & Richter, 2020), which is crucial when engaging with diverse groups of Rohingyas across three distinct camps. Rohingyas navigate the situation in each camp differently, as discussed in chapter 10.

6. Concluding Remarks

This chapter's analysis focuses on various factors influencing Rohingyas' childbirth experiences. It starts with the large-scale implementation of family planning programmes in Bangladesh. It continues with the local medical personnel, whose culture is heavily influenced by a widespread perception of birth as a polluted event, behind which they often conceal exclusionary discourses. Moreover, the humanitarian response applies principles derived from global health policies, but it does not consider Rohingyas' norms and needs. In line with global health policies, the humanitarian response initially involved the *dhoroni* in its policy. The *dhoroni* in the 1990s were employed by NGOs in the old camp; they were provided with the tools to operate in their shelters and assist women in giving birth. The policy of medicalising births was first implemented in the old camps and later in the new camps without the *dhoroni*, who are considered ineffective and are therefore excluded from the health facilities. The chapter examines the humanitarian response, which sometimes appears to misunderstand what it actually means to alleviate women's suffering. Many women opt for a home birth, despite lacking institutional support for this choice. The sense of protection fostered by kinship ties and neighbours in their shelters offsets their fears of hospitals. In some hospitals, the presence of birth attendants is not permitted, which leads women to refrain from attending these facilities. Instead, other camps allow *dhoroni* or a female relative to enter the delivery room. These minor adjustments promote facility-based deliveries. This analysis indicates that the role of *dhoroni* in their camps, how authorities enforce rules, and the use they make of certificates are all crucial factors for Rohingyas to consider when making a decision about the birthplace. These decisions tackle broader issues that, for Rohingyas, involve tangible fears, as explained in chapter 10.

Understanding Rohingyas' approaches to childbirth requires a precise analysis that incorporates their perspectives, along with an examination of relevant discourses such as local notions, health policies and humanitarian responses. These layers influence how birth occurs in the camps, the role that birth attendants can play, and how pregnant women are permitted to navigate this life event.

CHAPTER TEN Home or Hospital? An Analysis of How Rohingyas Give Birth in the Camps

1. Introduction

I go to the public hospital in Cox's Bazar ²⁰⁸ and visit its different wards. Before entering the female ward, I visit the ground and first floors. All kinds of patients lie on thin mattresses on the floor or even on beds with wooden structures placed in the hallway. All bodies are contracted, thin and small. Many people are sleeping (perhaps in the hope of temporarily escaping the physical pain and mental suffering), and their bodies form a "c": they lie down as if they have an incessant stomach ache and are going through contractions. A constant murmuring sound arises from them. Small groups of people (probably family members) surround the sick person. In this unknown space, they try to recreate intimate conversations. The heavy air of the Bangladeshi spring and the general atmosphere of uncertainty suffocate the sounds during this visit.

At the entrance of the female ward, the number of indoor patients is indicated on a board: "Rohingyas 0 – Myanmar Forced Displaced Persons 5". ²⁰⁹ After introducing myself and my research purposes, I ask at the reception whether the ward is hosting any Rohingyas, and a man at the reception desk makes a sign for me to follow him. I enter a huge room full of beds, and the man starts shouting: *Rohingya, Rohingya ache?* ²¹⁰ I am profoundly embarrassed by his behaviour. We walk to the end of the room, where a woman is sitting in a wheelchair. Next to her is a bed on which two women are sitting beside a person who is lying down. We start talking to these two women who arrived in Cox's Bazar yesterday evening. They were brought by ambulance from camp 25 because one was vomiting blood. She is with her daughter, who is much more talkative. The daughter is about thirty years old and tells me about her father, who died three or four months ago because he had the same problem as her mother. She tells me that today, they had to pay five takas to register at the hospital, ten takas for admission and five takas to copy all the relevant papers. They only got some food from the hospital at noon; otherwise, they had not eaten since they slept in Pahartoli. ²¹¹ They slept at "somebody's place", they say, but they are

²⁰⁸ As shown in image 1, Cox's Bazar is the closest city to the refugee camps in southeastern Bangladesh.

²⁰⁹ As outlined in chapter 4, the government of Bangladesh has officially addressed the newly arrived Rohingyas as "forcibly displaced Myanmar nationals".

²¹⁰ "Is there any Rohingyas?"

²¹¹ Pahartoli is a location in the neighbourhood of Cox's Bazar, but far away from the hospital and the city centre.

afraid to tell me where exactly. They want to protect their relatives living outside the camps. They tell me later after I have explained again what my purpose is. Meanwhile, a young teenager approaches us. She wears a pink headband and a yellow veil on her head. I ask her if she is with the two women. She replies, “I am an old Rohingya.”²¹² I am an old refugee,” meaning that she is from one of the two old camps. She is there with her mother, who has stomach problems. Suddenly, we are interrupted by a man who shouts at us because the woman in the wheelchair has fainted and is now lying on the floor! The general noise level in here is probably not as low as I initially perceived since we did not even realise that she had fallen. With the help of the young teenager, I grab the woman because her family members are not around. The old woman wakes up and starts grumbling something that makes no sense. I just hold her under her armpits and touch a swollen lymph node through her violet dress. I realise that I have reacted instinctively, but I may have worsened her situation by holding her incorrectly.

I leave the room. At the information desk, the receptionist tells me that Rohingyas come to this hospital for several reasons, but mainly because they fight among each other and then require surgery or the medicine ward. Afterwards, I speak to a physician who has been in this hospital for four months but still holds a less biased point of view than the receptionist. She explains to me that Rohingyas are mostly affected by HIV, Hepatitis A, B, and C. They have liver diseases, and among women, cases of uterine prolapse are common due to multiple pregnancies.

This chapter continues the analysis begun in the previous chapter to identify three ways for Rohingyas to navigate childbirth in the camps as “forced choices”, “survival strategies” and “adaptation”. Drawing on contributions from the anthropology of birth, the chapter will examine Rohingyas’ fears regarding hospital births. The remainder of the chapter will discuss the role of the *dhoroni* who supports women in the camps and their understanding of the body. Finally, based on some theories of the anthropology of the body, the chapter will outline three broad strategies that Rohingyas adopt in the camps to give birth. By examining the meanings that these strategies acquire for Rohingya women in three camps, this chapter seeks to analyse their various responses to social exclusion. Over the next several pages, it will be argued that the debate about the place of birth among the Rohingyas reflects broader issues, like their wish to give birth as they want to in a context of social

²¹² “Old Rohingyas”, “registered Rohingyas”, “old refugees” or “registered refugees” are used interchangeably to refer to Rohingyas currently residing in the two old camps. The rest are the “new Rohingyas”.

exclusion. Choosing their birthplace (at home or in a hospital) is tightly connected to Rohingya women's necessity of being at ease, and sometimes also to the collective attempt of forging a sense of community and belonging.

2. Theories: Critiques of the Medicalisation of Births

The current analysis of how Rohingyas give birth in the camps begins by highlighting five theoretical contributions that are insightful for broader debates on the medicalisation of births. As already mentioned in the introduction of this thesis, medicalisation of births usually refers to the "overuse of medical interventions even in low-risk pregnancies and childbirths" (Spina, 2023, p. 2), but in this context of refugee camps, already attending the health facility is perceived as a medical intervention, and hence medicalised births here refer to births in the camp health facilities.

In the nineteenth century, research in the United Kingdom demonstrated how the introduction of antenatal care and the medicalisation of births was presented as the solution to reducing mortality at birth, but not directly improving women's health (Oakley, 1984, p. 74). In fact, the mortality rate mainly concerns women's health, their access to food, living conditions, and other factors that, when addressed, positively affect maternal health and reduce infant mortality (Oakley, 1984, p. 68). Antenatal care services have introduced positive aspects as well. However, the research of sociologist Ann Oakley has shown that the socio-political context of a class- and gender-divided culture has brought in the assumption that women are unable to take care of their pregnancies and need medical care (Oakley, 1984, pp. 2, 292). As observed by anthropologist Veena Das (2015) for rural India, some diseases are inadequately treated, and death occurs despite the promoted government and global health policies. Such a context raises a question of biopower wherein some lives are preserved while others are not (Das, 2015, p. 52). In fact, this line of thought is not unique to the United Kingdom or rural India, but also applies to refugee camps in Bangladesh. A contradiction clearly emerges in the camps concerning reproductive health: while there is an imperative for women to give birth in health facilities to ensure their safety, issues such as malnutrition and general health are not prominently discussed in the debate on maternal and infant mortality.

In the United States, Emily Martin (1987) – also influenced by the work of Mary Douglas (1970) – claims that labour in health facilities is affected by several factors, such as environment, light, noise and movement, as well as the midwife, doctor or nurse's attitude

(63). She identifies a hierarchical system that has centralised the control of births (Martin, 1987, p. 66). This approach highlights the importance of the social context affecting women and their births. Many Rohingyas prefer to deliver their babies at home so that, as Martin explains for another context, women are able to control the process of birth and their own bodies (Martin, 1987, p. 143). In this way, the anthropologist explains in neo-Marxist terminology that pregnant women control the “means of reproduction” (Martin, 1987, p. 140). Although the debate among Rohingya women in the camps centres on the place of birth, during my fieldwork, it soon becomes clear that the setback, during hospitalised births, is that the medical personnel assign a marginal or even absent role to female social relations. Moreover, not all camp hospitals allow Rohingya *dhoroni* or birth attendants to operate within their facilities, as described in chapter 7. Instead, the significance of both social relations and the “Rohingya knowledge” emerges much more vividly during home-based births as female family members, neighbours and the *dhoroni* participate in this moment of passage. Again, Veena Das (2015) redirects academic attention to the fact that, despite the diffusion of global health policies in rural India controlling and ameliorating people’s lives, family and neighbours hold a crucial role concerning medical issues. In a comparable and similar manner, research with Rohingyas showcases that protection mechanisms are activated, for instance, through new kinship ties. These relationships counterbalance the mistrust of Rohingyas towards institutions (Islam et al., 2022, pp. 8, 22). In cases of chronic diseases, Rohingya refugees also seek help from different institutions, like the camp pharmacies managed by Rohingya doctors who have not completed their degrees due to discrimination in Myanmar. Despite their incomplete degrees, most Rohingya pharmacists are able to manage a pharmacy by paying a Bangladeshi national to secure a mandatory licence in their name. Due to their unrecognised legal status, neither as refugees nor as stateless persons, Rohingyas cannot be issued any official documents in Bangladesh. Moreover, Rohingyas might seek help from the *boidyo*, a traditional healer. Private healthcare is also common among Rohingyas due to a diffused sense of mistrust towards the public institutions outside the camp area or the humanitarian services in the camps (Islam et al., 2022, pp. 15, 18). Regarding reproductive health, Clémence Jullien’s study in India has shown that the use of health facilities depends on the community, particularly on the opinions of some family members, such as the mother-in-law, who decides most of the time whether a woman can give birth at home or in a hospital (Jullien, 2019, pp. 168, 170). Furthermore, the coercive approach of the state plays a considerable role, especially for family planning policies (see Fiks, 2024 as cited in Knoll, 2025).

Hospital births in a context of restricted mobility have hindered the presence of important social actors for pregnant women giving birth in the camps. Like Palestinian women, many Rohingyas have to cope with a situation that Livia Wick calls “loneliness” to describe women’s pregnancies away from their relatives in a condition of limited mobility (Wick, 2023, p. 30). Since 2010 and 2012, births have been medicalised in the two old camps. During my fieldwork in 2022, this rule was enforced in the other thirty-two new camps. In all thirty-four camps, the government of Bangladesh has implemented a policy of encampment since 2018. In other words, Rohingyas are not allowed to leave the camp area, unless for exceptional medical reasons that cannot be handled in the camps. A general sense of persistence, as well as other resources like establishing new social ties, has enabled Rohingyas to devise various strategies and decisions when giving birth, especially to feel as safe as possible. In a context of isolation, the *dharoni* or birth attendant plays a crucial role in assisting Rohingyas to give birth in their shelters in the new camp, as well as in alleviating fears about hospital births, due to the hostile attitudes of medical personnel, both in the old camp and the informal settlement camp.

In her study with *dhinebog* (Baluchi/Baloch midwives) in Pakistan, the medical anthropologist Fouzieyha Towghi has demonstrated that traditional midwifery and women’s preferences to be assisted by *dhinebog* have not vanished, despite the global drive to medicalise birth and the attacks on traditional midwifery (Towghi, 2024, p. 306). Such attempts have a long history because, already during colonial times in South Asia, authorities rarely recognised birth attendants. Their profession was seen as the cause of mortality at the moment of birth due to their allegedly unhygienic practices (Jullien, 2019). In colonial India, some missionaries adapted to the role of educators and trained some *daī* (birth attendants) in the basics of Western medicine because they were considered incompetent (Jullien, 2019, p. 36). The training element for “traditional” birth attendants was present even before global policies or humanitarian responses, and in countries like Bangladesh, it has mingled with hierarchical discourses. In line with this analysis, Towghi criticises the “reductive State and global health developmentalist discourses about the South Asian *daī*” that compromise the role of “traditional birth attendants” (Towghi, 2024, p. 306) and assumes that the biomedical Western system is the key to reducing mortality at birth (I. Ali et al., 2021).

These academic contributions strongly resonate within the camps and emphasise key points to consider when examining Rohingyas’ fears about hospital births. Rohingyas face, firstly, the contradiction of being requested to give birth in a hospital for their maternal

safety while being heavily malnourished. Then, the role played by social actors for Rohingyas in the camps is crucial, especially surrounding pregnant women during childbirth. Last but not least, several false assumptions sometimes lay the foundations for the implementation of policies in the camps.

3. Field Study: Fears Around the Event of Hospitalised Births

Based on interviews and field notes, female Rohingyas mention the word “fear” to me when approaching three topics. First, the eventuality of being forcefully repatriated back to Myanmar and enduring episodes of discrimination again is addressed with a note of profound anxiety. Second, a couple of Rohingyas have asked me to interrupt the recording of the interview while recounting some moments of their past migration. More concretely, they are afraid of being recriminated if the government of Bangladesh accesses the interview content. Third, fear arises when discussing giving birth in health facilities and related practices. These fears are connected to hospital births, probably because Rohingya women are afraid that if they all go to the health facilities of the camps, the humanitarian resources and related capacities will not be sufficient to assist them, or maybe they prefer to trust the social resources in their camp, or maybe they are influenced by all the unpredictable variables described so far. Lastly, the main preoccupation that they never directly mention to me is possibly related to stillbirths.

To begin with, women become particularly anxious about the cord being cut too early in the hospital. Many stories are told of newborns dying because the “nurses” ²¹³ in the hospital do not wait long enough to clamp the cord. In other words, Rohingyas fear that in the primary health centres of the camps, their cultural traditions would not be adequately respected. Experiencing the early clamping of the cord, as addressed in detail in the next section 5, provides ample motivation for Rohingya women staying home.

Despite being sheltered in a Muslim country, numerous Rohingyas do not want to venture into primary health centres to give birth due to the fear of breaching their religious or cultural values. During Ramadan, everybody fasts in the camps, including pregnant women. Fasting refers to the intake of food, drink and even medicine during the day because people fear Allah. In this rigid interpretation of fasting rules, it is considered wrong to interrupt the fast, even for a few pills. For this reason, it is likely that the number of pregnant women attending hospitals during the Ramadan period is lower. However, women do not fast for

²¹³ Rohingyas address midwives with the term “nurses”.

forty days after giving birth. Moreover, in hospitals Rohingyas have access to various forms of contraception. The discrepancy between the obvious non-implementation of these methods in the camps and this basic right available in all hospitals makes the Rohingyas' attitude of not interfering with Allah's wish even more evident. Rohingya refugees prefer to allow their pregnancies to proceed naturally, although Islam is not against medical or physical forms of contraception.

Another relevant fear of hospitalised births relates to the fact that birth is a phenomenon perceived as exclusively belonging to the female sphere and the presence of women.²¹⁴ Even the hypothesis that a male doctor could be present in the hospital is mentioned as a factor contributing to women's decision to stay at home.

During participant observations, I can observe the reactions of other women who accompany pregnant relatives to the hospital of the informal settlement camp, stay in the labour room, and are sometimes allowed in the delivery room. As the following ethnographic paragraphs show, the anxiety surrounding episiotomy²¹⁵ and other operations emerges clearly as another reason for Rohingyas to avoid hospitals.

Next to me, a pregnant woman's mother had been smiling proudly because her daughter is about to become a mother. The sudden change of expression on her mother's face is a clear indication that the operation has already taken place. With tears in her eyes, she leaves the room and stands in a corner, gripped with grief, her gaze on the floor. Later, the female doctor explains to me that:

"Rohingyas are against the side cut [i.e., episiotomy] because they believe that everything needs to be natural. All things must be done according to Allah's wishes!"

(R., personal communication, 18 September 2022)

Regardless of the reasons behind their point of view, what the doctor intentionally forgets is to ask for the pregnant woman's consent for this particular surgery. Additionally, some doctors do not even ask for women's consent to place a family planning method, as I witness during my preliminary research.

²¹⁴ I tried to study and observe discourses on death and burial practices among the Rohingyas, as the moment of birth within the cycle of life is connected to death. Unfortunately, among the Rohingyas, funerals and death are primarily managed by men, and I had limited access to cemeteries, funerals and the ablution (body-washing practices) for a deceased person, as required by Muslim tradition.

²¹⁵ After the woman's consent is given, the healthcare professional cuts the perineum and vaginal wall. In this way, there is more space for the baby to be born.

A female research participant living in a camp asks for my help with some documents that she cannot understand. Reading them together, we find out that she has agreed without any actual understanding of the medical procedure to have an implant – a long-term birth control method – placed under her skin. This and other similar cases have the effect of enhancing the fear of giving birth in health facilities. Many local physicians, midwives and nurses have adopted an approach that has been condemned by humanitarian social actors within the health sector, as observed also in other contexts like Cambodia (Guillou, 2013).

Finally, Rohingyas are tremendously afraid of giving birth in the hospitals outside the camps due to all types of surgery that this can entail. Most of the time, the reason for being referred to a hospital outside the camp area is exactly the necessity to operate on the pregnant woman. Caesareans are usually performed in hospitals outside the camps, such as in Kutupalong, Cox's Bazar, or even in one specialised health facility in camp 4, where the relevant skills and techniques are available. In particular, women are mostly afraid of Caesarean sections that, even if in certain cases are inevitable, are still too invasive for them. Interestingly, Lucy Lowe's (2019) research with pregnant Somali refugees in Kenya has explained their refusal of Caesarean sections as part of their strategy to protect themselves as migrants and mothers, as well as their future reproductive capacity (198).

In public hospitals outside the camps, lastly, medical staff charge additional fees for treating their patients, including both Rohingyas and Bangladeshis. In this manner, they primarily exploit individuals who are unable to contest the charges. Conversely, bribes rarely occur in the health facilities within the camps due to the presence of humanitarian social actors. So, Rohingyas prefer to stay in the camp area. Ultimately, Rohingyas who have some money and cannot be clinically helped in the camps go to private clinics, where doctors are less careful with people's health than in public hospitals, but at least they do not overcharge their patients. To better explore the fears of the interaction with medical personnel, the following section reflects on the perception of Bangladeshi midwives and the Rohingya *dhoroni*.

4. Social Actors: The Role of the Midwives and the *Dhoroni*

Pregnant Rohingyas avoid public hospitals outside the camps where they are often illegitimately asked to pay (e.g., for admission or registration) and have to interact with mostly prejudiced health personnel. They fear the scenario of hospitalised births due to the absence of the *dhoroni*, who cannot accompany them to hospitals outside the camps. In the

eventuality of an emergency, pregnant Rohingyas are transferred to a hospital outside the camp area and assisted by designated Bangladeshi midwives, frightening them the most. Bangladeshi nationals tend to assume a patronising attitude towards Rohingyas, which is partly justified with the differing perspectives of local midwives vis-à-vis “pollution” (see section 2 of the previous chapter). In camp hospitals, some Bangladeshi medical staff treat even Rohingya *dhoroni*, like Aicha or Naslima in the informal settlement camp, with an attitude of disgust (see chapter 6). Bangladeshi midwives, as mentioned, whose profession has recently been institutionalised in the country and who still occupy the lowest tier in the medical system, often treat *dhoroni* and Rohingyas with quasi-caste-biased and judgemental attitudes of superiority, observable in health facilities both outside and inside the camps.

The documentary film “*Midwives*” illustrates the birth practices followed by a Buddhist and a Muslim birth attendant who work for Rohingyas in Rakhine State but exclusively at home (Hlaing, 2023). There, the attitude of repulsion (often characterising midwives or *daī* in Bangladesh) is absent towards the *dhoroni*, who instead is respected by pregnant women, but is confronted directly with the threat of persecution. Thus, birth away from the hospital rather appears as a way to navigate a context of general hostility, exclusion and discrimination. While these factors have made hospital births in Myanmar inaccessible or unaffordable for Rohingyas, refugees have been encouraged to go to the camp health facility in Bangladesh where they are not persecuted but discriminated. Among Bangladeshi midwives and doctors, especially those working outside the camps, the aspect of pollution appears to be more dominant than Rohingyas are accustomed to, and a biased attitude towards refugees is common to observe. Regarding the local institutions and nationals employed at the camp hospital, their hostile attitude is often justified by the criticism that Rohingyas give birth at home. Such a critique appears contradictory because many women living in surrounding villages in Chittagong prefer home deliveries.

The hierarchy Rohingya women encounter in the camps does not encourage them to deliver in the health facilities. Besides, Rohingya *dhoroni* are not incentivised to work in the health sector, regardless of their role. Community health workers accompany pregnant women to the camp hospital, whereas “traditional” birth attendants assist them in delivering babies. In both cases, the medical personnel do not sufficiently acknowledge their work. Furthermore, the medical staff openly criticise Rohingyas’ home births, early marriages, their choice of having multiple pregnancies, and their social norms. They are mainly nationals who reprimand women for having several children without understanding the reasons

behind people's decisions, that more children lead to more resources, and earlier marriages lead to quicker alliances between families. Nationals often label this as a "primitive" or "uncivilised" way of thinking, reflecting the hierarchy in the camp hospitals, as well as the broader social exclusion affecting Rohingyas.

Rohingya women feel reassured when the *dhoroni* is present at birth for various reasons. In the informal settlement camp, the presence of the *dhoroni* in the hospital ensures that the pregnant woman is respected, feels safe and does not have to interact with midwives and the medical staff (see chapter 6). There, young Bangladeshi midwives with limited experience prefer to delegate as much as possible to the Rohingya birth attendants employed in the health facility. In the old camp, unemployed *dhoroni* accompany pregnant women to ensure that births occur in the health facility (see chapter 8). The *dhoroni*'s social protective and supportive attitude, along with the new alliances and kinship ties in the new camp, form a new system of reference for pregnant women delivering their babies in their shelters (see chapter 7). This choice offsets the episodes of injustice that emerge from multiple layers and discourses of exclusion in the hospitals. Last but not least, the *dhoroni* is one of the few women available at birth in the camps, and she sometimes receives something in return, like a gift or some money from the pregnant woman's family, for being present.

It is highly probable that the difference between the two figures of the *daī* and the *dhoroni*, to some extent, explains the different value-related dimension and reflects the ethnographic regional and socio-religious diversity between Bengali South Asia and Southeast Asian minorities. In Asian studies, the division of regional areas – such as South Asia and Southeast Asia – has long been addressed and debated as creating "categories of knowledge and ignorance" (van Schendel, 2002). *Geographies of knowing and geographies of ignorance: Jumping scale in Southeast Asia* is the title that historian Willem Van Schendel uses for one of his articles to emphasise the contradictions of regional categories in Asia: southeast Asia and south Asia are labels indicating areas of study to legitimate the production of certain types of knowledge (van Schendel, 2005). In this way, they become geographies of knowing. However, as he has extensively argued in his book *The Bengal borderland*, areas of study bear the risk of putting aside border regions that become geographies of ignorance because they do not survive as regional categories (van Schendel, 2005). This study cannot provide any final answers to this set of remaining questions. It may provide additional materials for their future elucidation, like throughout the analysis that follows on blood. The differences between the *daī* and the *dhoroni* are

connected to caste, as Rohingyas do not share the same ordered system as people in Bangladesh. The characteristic aspect of pollution is a pattern closely connected with the system of South Asian caste society and its hierarchical logic. In Bangladesh, the *daī* has a low status due to the polluting character of her job, regardless of whether she is Muslim, Hindu or Christian (Rozario, 1992, p. 169).

5. Reflections on Blood, Practices of Cutting the Umbilical Cord and Burying the Placenta

Rohingyas respect their social norms and practices, thereby setting boundaries that many women would never wish to cross at birth. This section presents some reflections on blood, the practice of clamping the umbilical cord and burying it, as well as the disposal of the placenta, all of which I observed as playing a central role during my fieldwork.

From Dumont's perspective, as discussed in his book *Homo Hierarchicus* and mentioned in chapter 9, birthing substances including blood are regarded as impure in India. As discussed, the Hindu caste system remains influential in Bangladesh even amongst the Muslim majority of the country. However, among Muslim communities, blood acquires different symbolic meanings that become mixed with local customs. Therefore, in Bangladesh two different interpretations of blood may coexist, considering the Islamisation of the Bengal region as a more recent layer in addition to the Hindu layer.

As mentioned in the introduction to this chapter, the patient transferred to the public hospital in Cox's Bazar after vomiting blood (hence, for an emergency) is also a relevant example regarding blood. Her husband died a few months ago from the same illness, and the way her daughter talks about her father's death reflects some ideas of Islamic medicine. If an individual spits blood for a long time, it is believed that they will inevitably die due to the polluted notion of blood (Ullmann, 1970, p. 58). On the one hand, blood is vital for human development, connected to descent and offspring. On the other hand, it is regarded as impure when it originates from menstruation or wounds (Campo, 2009, p. 109). In fact, the Muslim literary and medical traditions regarding blood are contradictory in their symbolic meanings. When a woman's menstruation ends for the month, she must perform an ablution, called *ghusl*, which is also carried out after childbirth and sexual activity (Campo, 2009, p. 109). For this reason, in chapter 6, Rubina mentions the *gusol* probably to refer to *ghusl* to emphasise, with a sense of irony, that despite the scarcity of water in the camp, they continue to respect their Muslim values. In chapter 6, at the end of a hospital birth, a

Bangladeshi midwife asks Naslima, the Rohingya birth attendant, to wash away the blood from the floor, and this request reflects the hierarchies within the delivery room of the camp hospital. Instead of washing the floor herself, the midwife instructs that the woman at the lowest level of the medical hierarchy undertakes the impure task. Rohingyas encounter these two distinct traditions in the camps, albeit from the margins. They experience the hierarchies prominently present in hospitals as a result of the Hindu belief system prevalent in Bangladesh, while the values that celebrate birth and are reflected in the work of *dhoroni* seem not to be acknowledged by other Bangladeshi Muslim nationals working in health facilities. The conception of birth has different meanings for Bangladeshis and Rohingyas, although most of them are Muslim. They have a common system of reference that can be found amongst similar Islamic practices they follow, but Rohingyas have been living in Rakhine State for long time and hence have another conception of the body and its health. In Bangladesh, Rohingyas encounter another value-related dimension of reproductive health that not only views their practices as “uncivilised”, but also belittles traditional practices because birth is related to pollution. It is worth noting that Rohingyas find themselves in a state of liminality not only as refugees, but also as experiencing two value-related dimensions around birth that become evident in these reflections on blood. In Malaysia, for instance, blood is also considered a substance that might expose women to danger during deliveries (Massard-Vincent, 1997, p. 213). For this reason, women follow some post-partum practices to restore their health. Blood is a symbol for well-being, which in Myanmar is explained with a notion of harmony between the body and the universe (Skidmore, 2002).

During the postpartum period in Southeast Asia, new mothers follow dietary habits (Delachet-Guillon, 2000, p. 27; Massard-Vincent, 1997, p. 213). Sometimes these are seen as food restrictions that not only mark the woman’s passage to maturity at the time of birth (Massard-Vincent, 1997, p. 214), but they are also primarily important for the well-being of the mother and the newborn. This set of beliefs also corresponds to a system of food categorisation, ranging from hot to cold foods, and foods that induce wind or acidity, hypertension, dizziness and drowsiness (Sein, 2013, p. 1259). It would explain why Rohingyas do not cut the umbilical cord immediately after birth: they avoid the induction of wind. This conception of therapeutic practices to heal the new mother are the result of variables, like, the imbalance of many body’s elements (Coderey, 2010). Furthermore, research has highlighted the importance of the “abdominal massage” for new mothers to clear the uterus, and separate positive and negative blood (Sein, 2013). Women in

Southeast Asia observe certain practices – such as hot-brick fomentation, home confinement, interruption of housework and abstinence from sex – because the postpartum period is a vulnerable stage in women's life (Sein, 2013, p. 1263). Hot-brick fomentation remains popular among the Rohingyas in the camps. These rites of passage acquire particularly relevance for women's health because, for example, the "warm" nature aims at re-establishing women's thermodynamic balance and strength (June et al., 2020, p. 1178). Overall, postpartum practices are conceived to restore the warmth of the body through dietary rules or rituals, such as the vaginal-care ritual involving squatting over a boiling pot of herb-infused water. In this view, the home is regarded as an environment that restores women after their pregnancies (June et al., 2020, pp. 1175, 1176).

As a more specific view of birth as the transition between pregnancy and newborn life, Rohingyas believe that both the baby and the placenta have to be expelled before cutting the umbilical cord. At the time of delivery, it might occur that the migration of the soul from the placenta to the baby's body may not occur immediately. In these cases, the placenta is placed next to a fire to warm it and accelerate this migratory process. The umbilical cord is only cut once the baby clearly shows signs of life, primarily through crying or breathing. Cutting the umbilical cord before the expulsion of the placenta is perceived among Rohingyas as an untimely and therefore dangerous practice, probably because in Islam the soul is believed to be separate from the body (Campo, 2009, p. 631). After the placenta is delivered, it is important to keep the baby and placenta connected until the baby is breathing to receive more blood and therefore blood cells, which carry oxygen and warmth. Interestingly, *nafs* and *ruh* are Arabic terms for soul and spirit, deriving from terms for breath and respiration (Campo, 2009, p. 631).

The placenta is considered supernatural in Southeast Asia and should not touch the soil (Massard-Vincent, 1997, p. 212). For this reason, Rohingyas usually place the placenta in a container before burying it. In Myanmar, as Fatima explains to me, Rohingyas used to dig one or two feet deep to bury the placenta of their newborns in an earthenware pot, হাঁড়ি, *harhi*, which is commonly available as a food container like yoghurt, as shown in image 39. Moreover, they cover the earthenware pot with a plastic bag to protect the baby's health (F., personal communication, 15 June 2022). Naslima explains to me that Rohingyas believe that if the placenta became contaminated, it would affect the baby's health (N., personal communication, 22 September 2022).²¹⁶

²¹⁶ Instead, anthropologist Thérèse Blanchet explains that the burial practices of the placenta are connected to issues of the mother's fertility (Blanchet, 1984, p. 90).

Rohingyas cannot easily buy yoghurt in the camps and thus do not own any earthenware pots. In this case, Nasrin and her mother Rubina use a couple of polythene bags to contain the placenta. They explain that burying the placenta has the practical reason of preventing dogs or foxes from eating it (N. & R., personal communication, 17 April 2022), but also for the spiritual reason of protection against evil spirits.²¹⁷ The burial place of the placenta acquires crucial significance for the Rohingyas who associate their place of birth with this location.

Observing this and other practices sheds light on how Rohingyas give birth in the context of refugee camps, when trying as well to respect certain norms. The lack of space in the camp area does not allow many Rohingyas who give birth at home to bury their placentas, but their families manage somehow. In contrast, those women delivering in the hospital have the medical personnel handle their placentas, which are thrown in the placenta pit. In one way or the other, they cope with camp life through new alliances either with other Rohingyas or humanitarian workers. Placenta burial practices, but also the clamping of the umbilical cord, demonstrate the inclination of Rohingyas to face difficulties and what kind of social ties they want to pursue. Based on their persistence and strategies, Rohingyas deal with the diverse responses in the three refugee camps. Overall, their distinct approaches are determined by the roles women play (unemployed birth attendant, community health worker and employed birth attendant), resources and many other experiences of their forced migration, leading each woman to cope differently with various practices.

²¹⁷ Many research participants used to bury their placenta in their garden or in open fields, whereas anthropologist Thérèse Blanchet, who has worked in rural Bangladesh, describes that the placenta is buried inside the hut (Blanchet, 1984, p. 90).



Image 39: হাঁড়ি, harhi, earthenware pots, containing yoghurt, and often used to bury the placenta.

6. From the Anthropology of the Body to Survival Strategy, Forced Choice, and Adaptation

Anthropology recognises the body as a relative concept that is strictly connected to society and the cosmos. There is a large volume of published studies that are not mentioned here because it is beyond the scope of this study to examine the whole literature on the body (see, for example, Lock, 1993). The reader should bear in mind that the following section is

based on some contributions that supported the present analysis to describe Rohingyas' ways to navigate the camp settings and give birth.

When Buddha was born, his mother, Mâya, was hanging straight from a branch of a tree and, like many women in the region, gave birth while standing (Mauss, 1936, p. 14). Likewise, Rohingyas giving birth at home prefer the standing position while holding the *rosi* – a piece of cloth that is usually hung from the top of a bamboo column in their shelter. Does the body of pregnant Rohingyas giving birth while standing and holding the *rosi* represent a sort of resistance to the medicalisation of birth? Some health facilities in the refugee camps have a piece of cloth installed on the ceiling of the delivery rooms to imitate this practice followed by Rohingyas at home. Nevertheless, women in labour are rarely allowed to give birth at their pace in the hospitals and do not use the *rosi* due to a lack of time. In anthropology, the body has been conceptualised in different ways. It is an instrument to accomplish certain “techniques”, as well as an object to control people, but also a means to express and perform values. For the first time, Marcel Mauss elaborates on the “*techniques du corps*” (body techniques). He interprets the body as the first instrument for humans, as well as the most natural technical object to use (Mauss, 1936, p. 10). The famous French anthropologist questions the conventional techniques of birth by presenting the common standing position in South Asia for delivering children (Mauss, 1936, p. 14). Mauss also classifies other techniques surrounding birth into various groups: those supporting the mother, those that depend on others supporting the pregnant woman, those related to the newborn's expulsion, and those regarding the umbilical cord used to heal the mother or the infant (Mauss, 1936, p. 14). All these techniques have the ultimate dimension of educating people's bodies (Mauss, 1936, p. 15), and they also tell a lot about people's values, as the practices analysed so far have demonstrated.

An important discussion for Rohingyas concerns the practices surrounding one specific part of their body: the umbilical cord. According to many Rohingyas, the medical staff in the hospital clamp too early the umbilical cord, which should not be cut until the baby cries. It is believed that throughout the pregnancy the baby's life is sustained by the *jol*, water – which in this context means placenta.²¹⁸ In cases of complications for the baby, it is common practice among Rohingyas to keep the placenta warm to protect the baby's soul

²¹⁸ A foreign midwife working for the United Nations Population Fund (UNFPA) in the camps explains to me that the Rohingyas' way of cutting the umbilical cord corresponds to the “wait-for-white” approach. In the medical discourse, this approach indicates the practice of cord clamping when the umbilical cord becomes white.

that is still in the placenta, and this warmth accelerate the process of transition to the baby's body. Giving birth at home may appear as a "survival strategy" for women who prefer to stand and follow preferred practices during delivery, like clamping the umbilical cord in respect of life.

The anthropological notion of "body" theoretically described as an instrument that does or does not refuse to be reified (Scheper-Hughes, 2004) defines Rohingyas' ways to navigate the camp scenario. Women's strategies are not limited to their decision of the birthplace, to give birth at home or in the hospital, but involve the specific decision on how to give birth. In the new camp, most women give birth at home, and access to basic resources (like the birth certificate) might be then negotiated according to other survival strategies. In the end, since in Islam the biological and social birth coincide (Massard-Vincent, 1997, p. 214), some Rohingyas might even give less significance to the issuance of birth certificates: the newborn belongs to the Rohingyas and to the *umma*, the community of believers, as soon as an Imam, their father or a male person whispers the *adhan*, call to prayer in its left ear.

Bodies are described in prominent anthropological contributions as the first natural tool available.²¹⁹ Rohingyas' bodies acquire additional significance as they resist experiences of birth in hostile and unknown contexts. Besides, the body gains the function of a unique instrument of autonomy for women as "the only thing that is left" to them, as Fatima the *dhoroni* in the new camp who assists home births once explained to me. In fact, in the new camp, female bodies appear as one of the few resources left to Rohingya women. Since 2017, women have used their bodies as a tool and reference to cope with their condition of displacement and exclusion. They do not have as many resources as refugees in the old camp or the informal settlement camp. At the hospital, they cannot give birth at their own pace, and other women are not allowed to accompany them. There, birth attendants occupy a marginal position, while relatives and neighbours are absent. Furthermore, many women live far away from their families of origin and stay at home to accomplish nurturing tasks. Together with the female relatives available, neighbours and a *dhoroni*, they manage to construct new social ties, crucial to supporting their home births.

In the primary health centre of the informal settlement camp, the birth attendant Naslima explains to me that the bodies of Rohingyas are rendered weak by camp life. In the context

²¹⁹ For example, athletes like boxers who self-produce their bodies are compared to body artisans (Scheper-Hughes, 2004).

of the camps due to the living conditions, Rohingyas are “vulnerable” and Naslima describes facility-based births as a necessity.

“When we were back in Burma, we used to cultivate. We could harvest once a year. But now, here, everything is available, and food is produced using huge amounts of fertilisers. By consuming them, we do not receive as much nutrition as we need. That's why we are becoming vulnerable. At that time, if we had gone to the hospital and had a side cut, the delivery would have been very straightforward. But now those who have *dharoni* at home say, ‘No, I will not go [to the hospital] because I have had many deliveries at home before. Why do I need to go to the hospital?’

We have to work hard and cultivate the land [in Myanmar]! Doing the household chores! Working in the vegetable gardens! But here we do not have much work, and we are all bored. We are very weak and vulnerable, seated, and only spend time seated whilst consuming ready-made food. We need to go to the hospital and have the delivery there. Only then will it be smooth for us because here we are, helpless at home. But in the hospital, we will receive the medicine, and we will get an injection that you can't get in the nearby pharmacies. That's why we advise them to come to the hospital.”

(N., personal communication, 28 September 2022)

Naslima describes the process of giving birth at home as obsolete in the history of Rohingya women's bodies. Her words re-evoked the “muscular contractions” that Frantz Fanon mentions to describe the body of many people rejecting colonial authority (Fanon, 1961/2007, p. 210). In the context of refugee camps, Rohingya women are constrained to a life neither as active nor as well-nourished as it used to be in Myanmar. In their frail physical condition, home births become a risk.²²⁰ Naslima agrees that some birth practices should be abandoned and substituted with the use of medicines, as the status of women in the camps is too weak. While Naslima presents hospitalised birth as a necessity, I regard it as a “choice”. The majority of Rohingyas give birth in health facilities because they also feel safer there. Community health workers like Rubina attempt to make pregnant women feel at ease within the health facility already during the antenatal care check-in, and birth attendants like Naslima and Aicha assist them most of the time with their deliveries. Still, it

²²⁰ Some research conducted in refugee camps in the Global South and border areas, like the Thai-Myanmar border or the Shire camps in Ethiopia, has highlighted similar issues, such as malnutrition, the need for iron-folic acid supplementation for pregnant women, as well as the importance of training for skilled birth attendants to deal with complicated births and the general deprioritisation of newborns' health during humanitarian responses (Dimassi et al., 2023; Getachew et al., 2018; Parr et al., 2014; Sami et al., 2018).

remains a forced choice, given their generally fragile physical condition. Finally, the talk with a doctor working next to the informal settlement camp and the birth of a Rohingya woman living in the “model camp” better explain the use of the word “choice”.

Doctor Nadin, the clinical lead of the Médecins Sans Frontières hospital, tells me about the numerous services that they offer to pregnant women near the camp area: antenatal care services, check-ups, vaccinations, episiotomy, vaginal birth and post-natal care are all services available to both Rohingyas and the local population.²²¹ In cases of predictable necessity for a Caesarean operation, he refers the pregnant woman to Cox’s Bazar public hospital or Hope Hospital in camp 4. Many Rohingyas who visit this Médecins Sans Frontières hospital for antenatal care ultimately decide to give birth at home, he explains to me. “Only if the newborn does not cry,” he says, will they come from their shelter to this structure to check the baby’s health. However, his point of view is that home births occur quite often in the surrounding camps because of the social exclusion of women. No male member is at home at the right moment to accompany the pregnant woman to the hospital, or they have no personal vehicle and are unable to arrange a tom tom.²²² These are the main reasons that constrain Rohingyas to give birth at home. In fact, many are willing to deliver in the hospital, the Bangladeshi doctor says, but they are not mobile enough. Sometimes, there are also frequent situations where male members prefer to stay at home for reasons of privacy or religion.

The informal conversation with Dr. Nadin highlights two different scenarios for home deliveries. The first depicts Rohingyas as restrained in their mobility, both in terms of gender-specific limitations – i.e., young women who avoid leaving their place on their own without a male relative – and as refugees in general, who either do not own any vehicles or are unable to manage one. The second dynamic involves some relatives’ reluctance or even obstinacy towards women attending the health facility. In these cases, the decision to give birth at home seems to be made by male relatives to protect the pregnant woman and counterbalance the institutional pressure for facility-based births. Many Rohingya women, both inside and outside camps, appear to protect their relatives and would rarely criticise their husbands. Nevertheless, birth practices are frequently described as belonging to the female sphere, and the following instance ultimately confirms that the final decision on the

²²¹ The Médecins Sans Frontières hospital is next to the informal settlement camp, but outside the camp area.

²²² Motor-driven rickshaws on three wheels are called tom tom in Bangladesh and tuk tuk elsewhere in Asia. Together with CNGs, tom tom are the most popular means of transport in Bangladesh.

birthplace is a choice attributed to the pregnant woman or, at least, a female relative among the Rohingyas.

We stroll through the model camp with a community health worker who eventually invites my research assistant and me to her home. She does not want to continue working today because she is exhausted. She tells us that she is very tired after having spent three days and two nights supporting a pregnant woman who was referred to Hope Hospital in camp 4. That lady was pregnant with her fourth baby and exceptionally insisted on having a Caesarean operation, but her husband and father-in-law disagreed with her. She insisted because she did not want to leave her other children without a mother, while her male relatives completely opposed her. The issue with her pregnancy concerned the baby's position, and the Caesarean was inevitable. In this case, the woman stood up for her Caesarean operation. This represents an example of a woman having a say over her own body, and her choice resonates with all its strength. Probably, the community health worker has mediated both linguistically and culturally between the pregnant woman and the local doctors or midwives and accurately collected the woman's consent.

In some cases, hospital births are crucial for many women who are malnourished, as Naslima points out. However, Rohingyas can pursue their decision to give birth in the hospital, but within limited conditions. Hence, they make a "forced choice"; an appropriate manner to describe the response of many women in the informal settlement camp and nearby camps.

Rohingyas' "forced choice" has led me to reconsider my stance regarding home births. At the beginning of my fieldwork, I romanticised birth at home as a way for refugees to feel closer to their places of origin. In this way, I depoliticised the Rohingyas' condition back in Myanmar. I then realised that I was disregarding the elements of systemic discrimination as home birth is the only option for Rohingya women who are denied access to hospitals in Rakhine State. Liisa Malkki (1995) has contributed to this debate through the notion of exile and its risks highlighting the importance of looking behind at the political and historical contexts that force people to migrate:

"Belonging and not belonging (uprooting, exile) to a place are spiritualised in a broad sense of the word. And this spiritualisation can lead to dehistoricization and depoliticization." (Malkki, 1995, p. 514).

Thanks to this critique, which disagrees with the assumption that displaced people need to connect to their place of origin, I have started looking at birth at home as a way for Rohingyas to navigate the context of hostility, exclusion and discrimination in Myanmar. These factors make hospitals inaccessible or unaffordable for Rohingyas in their country of origin. In contrast, in the old camp, hospitalised births are not only mandatory but also a moment for many Rohingya women to manifest their proximity to the humanitarian system. For more than a decade, refugees have been asked to go to the health facility in the old camp. In a country like Bangladesh, where overpopulation has been an issue ever since its independence in the early 1970s, refugees are often considered a “surplus population” in demographic and economic terms. The camp scenario in Bangladesh has brought them to be confronted with different dynamics over the decades. Bangladeshi humanitarian workers have actively promoted family planning programmes among the refugee population of Rohingyas, and the regional administration implemented its respective position on reproductive health explicitly during the 1990s, as population growth in the camps triggered institutional anxiety (Médecins Sans Frontières Holland, 2002, p. 16). More specifically, three shifts have happened in the field of reproductive health in the old camp.

Dhoroni were initially included in the reproductive policy, and forty from the two old camps received training as “traditional birth attendants” to assist with births in Rohingyas’ shelters (Hossain, 2010, p. 2). Moreover, one hundred male and female volunteers were also trained as community health workers to promote certain hygienic practices (Hossain, 2010, p. 2). Community health workers have outnumbered the *dhoroni* employed as birth attendants, and they have gradually replaced the latter. This shift has coincided with the shift in global health policies that first included birth attendants in their programmes and later excluded them. Besides, this political shift might have happened simultaneously when Médecins Sans Frontières left the old camp, namely when the organisation interfered with sterilisation policies and the governmental programmes of repatriation (see chapter 3).²²³ As mentioned in chapter 9, the departure of Médecins Sans Frontières from the old camp shed light on a third shift in the reproductive health policies. In 2001, the government of Bangladesh suggested that sterilisation and abortion services could also be introduced (Feeny, 2001, p. 54). Once the United Nations High Commissioner for Refugees, the World Food Programme, Médecins Sans Frontières Holland and Concern Worldwide opposed

²²³ See also *Chapter 1 – 1990s – Advocating against Rohingya Forced Repatriation from Bangladesh to Myanmar* (Binet, 2020, pp. 38, 45, 50).

implementing sterilisation services, the government attempted to offer food to solicit women to adopt birth control methods (Feeny, 2001). This manoeuvre resembled other current practices of institutions denying birth certificates, family cards and, therefore, rations of food to children born at home. Médecins Sans Frontières defined this government proposal as unethical (Feeny, 2001, p. 54). Because of the United Nations High Commissioner for Refugees funding of medical services that the Ministry of Health could take over, Médecins Sans Frontières was finally expelled from the old camp in 2003 (Binet, 2020, pp. 103, 104).

224

To put it in a nutshell, Médecins Sans Frontières' and other organisations' initial approach consisted of implementing safe births at home. They included the *dhoroni* from the outset in their approaches. This decision supported refugees' lifestyles and was financially affordable. Given the increased financial support for the humanitarian response since 2012 and 2017, as well as the political shift in global health, services offered to pregnant women must take place in hospitals. Services have become much more sophisticated, and births have increasingly become medicalised. However, no official document has directly addressed this regulation medicalising births in the old camps since 2010-2012, and only Rohingyas' stories and certificates confirm this chronology of reproductive health policies in the old camp. Rohingyas' way to navigate the implementation of these rules might be analysed with the notion of *habitus* suggested by Pierre Bourdieu.

Bourdieu's theory of practice explains how experiences of knowledge are constructed, namely through the *habitus* and its practical functions. The social process of people living in the same conditions allows the incorporated *habitus* to act in and through their bodies (Bourdieu, 1980/2005, pp. 91, 93). In this context, the *doxa* (i.e., the praxis) is the practical belief that links the *habitus* to its enactment, performance or application (Bourdieu, 1980/2005, p. 107). Dominant behaviours, attitudes and manners are taught under the pretext of demanding the body to accomplish some futile tasks, while pedagogy defines the social qualities of the body and its movements (Bourdieu, 1980/2005, pp. 108, 111). The body reproduces knowledge in terms of imitation, and the use of the body is crucial to protect traditions, especially in oral cultures (Bourdieu, 1980/2005, p. 115).

Rohingya women have adapted to the surroundings of the old camp and have complied with the rule of medicalised births because they have been living in the humanitarian system for more than thirty years. They are not discouraged by this choice and

²²⁴ Probably due to these hostilities with the government, the Médecins Sans Frontières health facility – where Dr. Nadin worked – is located outside the camp area.

continue to visit the health facility with a *dhoroni*, who regularly assists them in delivering their babies. *Dhoroni* like Moriam advocate for other women to have a *rosi* (rope) to hold onto in the delivery room of the hospital during childbirth. This supports them to give birth at their own pace and in the manner they prefer. The women in the old camp who have lived in this context for more than thirty years adapt to the reality of medicalised births as a form of “habituation” or “adaptation”.

The conceptual considerations regarding the body of Rohingyas support the present analysis of women’s approaches to give birth in different camps within multiple exclusionary dynamics, as they want to. Life in a refugee camp partly dispossesses people of their authority. Refugees are not allowed to move freely, and women have limited opportunities to make decisions. The place of birth or, better said, how women give birth gains significance because women’s bodies often appear as the only resources remaining to them. In some cases, they still retain a fundamental core authority despite their bodies’ restricted mobility, social exclusion and their fears.

7. Concluding Remarks

The body has constituted a crucial layer for the current chapter in analysing Rohingya women’s coping strategies, as well as their values and fears during childbirth in the camps. During labour, standing seems to be a way for Rohingya women who give birth in their shelters to resist imposed birth methods: many women in the new camp remain at home as a survival strategy to deliver according to their wishes. In the context of the hospital, birth attendants are marginalised and relatives are absent, although social ties with other Rohingyas remain fundamental for pregnant women. In the informal settlement camp, bodies are depicted as weak, and the birth attendant Naslima describes home births as obsolete. Women who give birth in a hospital do so because of their weakened condition. Thus, they make a “forced choice”. In the old camp, the high rate of medicalised births reflects Rohingyas’ proximity to NGOs and the consequences of years of policies pursued by nationals, concerned about the surplus refugee population. Birth attendants were initially involved in the NGO response to assist with home births safely. Later, they were almost entirely replaced by community health workers. As a result, Rohingyas have adapted to a context of medicalised birth, given their extended stay in the camp, and have abided by the rule because a *dhoroni* is present without being paid at each medicalised delivery.

Within the many laws governing refugees in their camp life, as presented in chapter 9, Rohingya women can cope differently with the general rule of medicalised births and

power dynamics in the hospitals, while respecting their norms and practices. Their bodies reveal their fears, but also how they wish to give birth according to the camp they live in, as well as the resources available to them.

Conclusion of Part Three

Part three examines multiple layers of social exclusion faced by Rohingya women during labour and delivery. In chapter 9, this analysis considers the national context, the humanitarian response in its different phases, informal and formal resources, and social ties as key factors. Several discourses influence the policies implemented in the field of reproductive health, while chapter 10 takes a different approach to understanding how Rohingyas cope with labour and delivery in the camps.

The anthropology of birth forms the core of my analysis. Bodies serve as a crucial layer for understanding Rohingya women's approaches to childbirth in each of the three camps. In the informal settlement camp, women have some margin of choice because of the overall inclusion of many Rohingyas in the humanitarian response. The protracted camp life has weakened Rohingyas' health, and their ability to give birth at home is limited. Rohingyas have lived in the old camp for more than thirty years and have adapted to some rules. The *dhoroni*'s assistance during labour and delivery is a compromise for many women to follow the rule of medicalised births and deliver at the hospital. The words "survival strategies" do not directly relate to the bodies of Rohingyas, although they are connected to the thesis title *Our bodies are the only things that are left to us*. Instead, they refer to the small objects and practices used during labour and delivery at home, as well as the mutual support that encourages many women in the second camp to give birth at home.

CONCLUSION OF THE DOCTORAL THESIS Creating New Life Within and Despite Social Exclusion

1. Social Exclusion for Rohingya Women in Refugee Camps in Bangladesh

As for Rohingyas in Bangladesh have been exposed to systematic violence and exclusion, research has shown that various issues of mistrust arise when refugees approach medical services within the camps (Islam et al., 2022). This thesis provides a basis for explaining the dynamics of mistrust and fear towards medical services offered in the camps.

The Rohingyas face a general condition of social exclusion, the result of the complex and protracted process of general partition of the British colonial empire, criminalisation and persecution of certain population sections during nation-building in Myanmar. The term “forced migration” sheds light on the fact that the historical dimensions should be considered to understand the displacement of Rohingyas and opens the way for an important legal discussion. The analysis of emic categories offers a general overview of the policies that have contributed to the Rohingyas’ exclusion. Depending on their experiences, Rohingyas have created their own networks, strategies and informal resources within the camps.

In the domain of reproductive health, this study has shown that Rohingya women have manifested their preference for home births in certain camps or, at least, to be assisted by their own community members and birth attendants in other camps. This difference is shaped by the year of forced migration, the years spent in camps, and the resources to which they have access. This study highlights these links to demonstrate that the institutional approach criticising the increased rates of child marriage and polygamy among Rohingyas (Melnikas et al., 2020) does not necessarily achieve the official objective of medicalising more births in all the camps. Instead, it discourages women from attending health facilities. Besides, the denial of a birth certificate is not an incentive for the general policy of medicalising births. Since many pregnant women have relied on Rohingya health workers and birth attendants, it would be beneficial for the whole humanitarian system to include more of them officially.

This research has contributed to the understanding of Rohingya forced migration, providing further insight from the Rohingya perspective on their persecution in Myanmar, and expanding the literature on refugees in the Global South. Moreover, this study has expanded on the discussions of the term “Rohingya”, which usually encompasses only Muslims, but *de facto* also has included Hindu and Christian Rohingyas. Furthermore, it has

also emphasised the importance of other terms, such as “*Jerbadi/Zerbadi*”, which are used to refer to Rohingyas among the population in Chittagong, as well as to indicate the children of Buddhist women and Indian men in Rakhine State (Yegar, 1972, p. 33). Overall, this thesis has attempted to showcase various levels of social exclusion intertwining at the moment of birth for Rohingya women, who are also very diverse on how they approach childbirth depending on their roles, age, years spent in the camps, emic categories and when they underwent forced migration.

This research has an impact in terms of involving women, refugees, humanitarian work, and reproductive health policies. It reflects, studies, and provides answers on the condition of forcibly displaced women and their experiences of giving birth to stateless newborns. In this regard, the place of birth has played an important role in the debate among the stateless resident population in Bangladesh, as it influences access to birth certificates and a range of services for newborns for a certain period. Promoting the inclusion of more birth attendants within the health system is a significant step to improve life in the camps and make pregnant women feel safer in hospital settings. The presence of the *dhoroni* would not completely eliminate the condition of social exclusion, but it improves to some extent the Rohingyas’ experience. Supporting this initiative could encourage many women to access facilities more easily and reduce their hesitation — even during complications — to seek hospital care. In this way, maternal mortality rates could decrease, and fewer pregnant women would be afraid to attend hospitals. A strong hierarchy of knowledge in the primary health centres would persist, where the medical personnel would still largely consider Rohingyas as illiterate.

The present work has focused on the experience of birth in refugee camps and has revealed the condition of Rohingya women in the Global South. Stateless, they are protractedly displaced in refugee camps, and this condition should be taken care of by the institutional social actors involved in the protection of refugees, like the UNHCR. Working with women has significant implications: this study highlights their perspectives and attempts to make their concerns visible, ensuring their voices are finally heard and documented. In particular, they have revealed how they wish to give birth, depending on the camp they live in and the resources available to them. All this should be taken into account when planning for future activities in the fields of migration and reproductive health policies.

Presenting female viewpoints during such an intimate and fundamental moment in a woman’s life should continue to be a priority in research. The experience of Rohingya women already today is a topic of some concern for the Bangladesh government. For

instance, policies have been implemented to regulate the number of children born in the camps, while NGOs have developed policies with no immediate effects. Overcrowded camps are a concern for many governments in the Global South. Hence, the material of this work is crucial to clarify the reasons why refugee women do not trust institutions, their structures, services, policies, and objectives. This issue is central in terms of policies, as well as in the life trajectory of human beings who live in the limbo of refugee camps and statelessness.

Despite being socially excluded, displaced from their own country and experiencing systemic episodes of violence, Rohingya women deserve attention in academia and in researchers' interest. Making their wishes visible is one among several preconditions for practical changes. Refugee women are often depicted as vulnerable and incapable of expressing their desires. In some camps, their wishes have been harder to address due to the limits of this research, but their bodies have spoken loud and clear. There still is limited ethnographic material on life in the camps: therefore, this work attempts to reiterate and reflect upon what Rohingya mothers and other women have tried to communicate to me during my fieldwork.

2. Key Theories and Additional Theoretical Validation

This section highlights the theories that have informed and supported this work, and hence, the theoretical references. Three distinct yet interrelated streams of theories support the present work in its three parts. While it is not always possible to keep them separate, I will outline the relevant features of each.

Social exclusion is a complex continuum that acquires various forms depending on temporalities and stages in the life of refugees (Foblets et al., 2018). The main contribution of this theoretical approach is that it opens up the range of exclusion mechanisms that refugees might endure. Such an approach argues that exclusion is connected to legality, but it emphasises that legal statuses are not sufficient to investigate exclusion (Foblets et al., 2018, p. 30). In fact, exclusion is multidimensional and enacted in the everyday life of migrants or refugees (Foblets et al., 2018, p. 29). Since these authors have mainly researched on Europe, some aspects of forced displacement in the Global South are less of a focus in their contributions. With reference to refugee-related law in Asia, Chimni expands on this debate by emphasising that the most accurate approach to studying the Asian context, where only a few countries have signed the 1951 *Geneva Convention Relating to the Status of Refugees*, is to analyse each scenario *ad hoc* (Chimni, 2009).

Chimni's contribution has been essential for the present study to explore emic terms among Rohingyas to understand the legal context. Moreover, Foblets et al. mention the importance of inter-disciplinary analysis, but do not look into the role of history, which plays a significant role in the study of forced migration, especially in certain regions in Asia where nation-states have been recently established, as the scholars Banerjee and Samaddar (2019) argue. Legal, as well as historical discourses are essential to better understand the epistemological formation of refugees in certain areas of the world. Malkki (1995) re-evokes the expression used by the philosopher Michel Foucault "the order of things" to describe refugees' position outside society (Malkki, 1995). Even though Malkki has researched among Hutu refugees in Tanzania, her approach, which focused on the epistemologies of exclusion, has inspired a generation of anthropologists working with refugees in different parts of the world. For instance, the work of Annika Lems in a European context focuses on the phenomenology characterising everyday exclusionary practices of refugees. The anthropologist examines social processes and specific practices of boundary drawing (Lems, 2020). These practices are activated by several actors within different narratives, as Foblets et al. have identified in their six constitutive elements of exclusion, i.e. actors, acts, moments, representations, areas and reactions (Foblets et al., 2018, p. 3). Similarly, the term "biopolitics multiple" has been used to describe the multiple layers of politics affecting refugees (Aradau & Tazzioli, 2020) and are activated by various social actors. In this regard, as detailed in the next paragraph, Didier Fassin's (2010) contribution has expanded this explanation of control and introduced the notion of "politics of life", which underlines the humanitarian goal to alleviate people's suffering. Still, the massive presence of NGOs to keep order in refugee camps may cause the restrictive implementation of certain acts, like isolating refugees within the confines of the camps (Agier, 2011). One criticism of much of the literature on NGOs and humanitarianism is that it does not adequately consider refugees' strategies and social ties, which are often the basis for exploring life in refugee camps (Harrell-Bond, 1986; Huq & Miraftab, 2020; Malkki, 1997). Besides, informal resources and social ties are crucial factors in understanding refugees and their interactions within the context of a borderland like in the region between Chittagong and Rakhine State (van Schendel, 2005). The social interaction and the mobility of some Rohingyas stand out as essential elements, especially when considering their condition of social exclusion in Bangladesh. Generally, social exclusion can be classified as a result of a wide range of rules and laws, as suggested in one of the definitions of legal pluralism provided in the domain of legal anthropology (Benda-Beckmann & Benda-Beckmann, 2013).

On the question of social exclusion in the field of reproductive health, three key theoretical aspects require to be addressed in order to have a thorough picture of the discourses surrounding births in the refugee camps. First, reproductive health encompasses regional cultural notions surrounding births, humanitarian policies, and global health policies. The regional approach on birth in South Asia highlights the notion of “pollution” (Blanchet, 1984; Jeffery et al., 1989; Rozario & Samuel, 2002). With particular reference to the study of Rohingyas, this notion is crucial because exclusionary discourses hide behind representations of birth as a contaminated event, as well as power asymmetries that are manifested by the medical personnel in Bangladesh. Second, global health policies have promoted the medicalisation of births worldwide to reduce mortality rates (MacDonald, 2022), starting from the false assumption that the medical Western system is the key to reducing mortality at birth (I. Ali et al., 2021). These policies have impacted the role of “traditional birth attendants” in Asia and elsewhere by introducing hierarchical relations, as well as the “authoritative knowledge” (Jordan, 1997) that establishes the biomedical tradition as the standard. They have also led to a discursive shift in the field of midwifery in Bangladesh where, since the independence, family planning programmes have been progressively implemented also due to the USAID intervention (Mookherjee, 2007, p. 345). These political initiatives have not reduced the mortality rate of mothers, while the birth rate has generally declined. Being promoted again through more recent humanitarian responses, like the Rohingya response, these global health policies should not be explained merely by notions of biopolitics. The conceptualisation of life in refugee camps is crucial for policy development. However, reproductive health requires to be approached not just in terms of power dynamics, like in the control of the refugee population, but also in terms of “the politics of life” (Fassin, 2010) as the third theoretical point to be considered here. In other words, the humanitarian response alleviates refugees’ suffering and does not aim at merely controlling them. To sum up, the three key theoretical factors requiring consideration when examining social exclusion in the field of reproductive health in Bangladesh’s Rohingya refugee camps are:

- 1.) national and regional cultural notions surrounding births,
- 2.) global health policies and
- 3.) humanitarian policies.

As an anthropologist, I offer to provide further theoretical substantiation for each of these three points:

The national medical personnel in the camps approach birth and birthing substances with a sense of disgust and repulsion: they are “polluted”. These discourses can be observed as a way to express exclusionary dynamics towards the Rohingyas. In the country, through different policies, the dominant narratives in the field of reproductive health promote hospital-based births and the implementation of family planning.

Turning to childbirth and how Rohingyas wish to give birth in the camps, a critical approach is necessary to examine the medicalisation of birth. The work of Fouzieyha Towghi in Pakistan has contributed to questioning the dominant discourse of medicalising births and has questioned biopolitical knowledge as the solution for women, who would, otherwise, look for the support of the so-called “traditional birth attendants” (Towghi, 2024). This work has been fundamental in order to analyse the policies and practices that a) exclude Rohingya birth attendants from health facilities, and b) deny Rohingya newborns birth certificates if delivered at home. Despite these constraints and general camp rules, Livia Wick’s contribution, conducted in Palestine with pregnant women, has been particularly relevant to sustain the argument of the present PhD thesis (Wick, 2023). Because of their restricted mobility, pregnant women in Palestine experience childbearing as a profound condition of isolation, away from fundamental support and assistance, both medical and emotional. To navigate such a social and emotional impasse, Wick has emphasised in her analysis the importance of the notion of *Sumūd*, “endurance”, which enables Palestinian women to establish new relationships and cultivate a general sense of persistence that guides them throughout their pregnancies and births. To examine the diversity of Rohingya women’s responses to the overall situation in three different camps, some contributions on the anthropology of the body have sustained my analysis (Bourdieu, 1980/2005; Das, 2015; Fanon, 1961/2007; Mauss, 1936; Scheper-Hughes, 2004). Rohingya women resist through their own bodies, as well as through social ties that are often neglected and excluded from the context of hospitals.

My original contribution is to approach topics at the intersection of refugee camps and reproductive health. The discussion among Rohingya pregnant women in the camps centres on a safe place to give birth from their points of view. The moment of birth is, in fact, a crucial rite of passage in people’s lives (Newman, 2001), especially in a context of displacement

and statelessness. Stateless people are not automatically granted citizenship in Bangladesh, and they would face concrete problems in terms of their legal recognition in almost every country of the world. Their condition contrasts with the experience of the majority of human beings who are recognised as citizens once they are born. This does not occur for Rohingyas; besides, Rohingyas born at home are recurrently denied their birth certificates for an unpredictable period by the authorities in the camps. There, institutions want to make sure that the rule of medicalised birth is respected. Still, many women stay in their shelters to give birth, and this decision resonates significantly as the place of birth appears more important than receiving a birth certificate. Giving birth for Rohingya women is closely linked to a sense of belonging and being at ease. Apart from the choice of a hospital/home birth, it is one of the rare moments when they are free to make their voices heard. These decisions require to be located in broader exclusionary discourses affecting Rohingyas historically and legally. Therefore, I developed interconnected arguments to systematically analyse how these discourses against Rohingyas have been rooted in the context of Bangladesh.

3. Reflections and Research Trajectories

Before concluding this thesis by summarising its main results, it is hoped that readers will permit the author a moment of self-reflection. My previous work on asylum law has provided a solid basis for elaborating on significant topics in refugee studies, such as the absence of refugee-related law, refugees in the Global South, and refugee camps. I have expanded my theoretical knowledge while studying anthropology at the University of Vienna, where discussions around the topic of migration have been prominent for years before 2015 but mainly regarding Europe. Moreover, I have been inspired by the refugee studies curriculum in Oxford where the understanding of research is particularly imprinted by Barbara Harrell-Bond's approach to legal anthropology. These are starting points that have enabled me to dedicate time and effort to studying the region, and learning the necessary languages. I have been particularly excited to study systematically a new language, culture and history in Paris at the INALCO, where the technical study of Bengali is coupled with sociology, anthropology, history and geography. I looked with extreme interest at the research on and with a group of refugees like the Rohingyas also because their country of origin is close to where they now live. Combining these two academic layers of refugee studies and asylum law, along with studies on South Asia, has enabled me to approach my research topic in an enriching and challenging way. Collaborating with a local university has been a great

opportunity to work together with other students and colleagues, to exchange and expand ideas, and understand certain concepts from a new perspective.

The necessity to conduct extensive research with stateless people in protracted displacement, who face challenging life conditions among refugees worldwide is crucial. The answers of women, who are persistent in facing their everyday challenges, is empowering and a great resource for other non-citizens who could find themselves in situations of displacement. Last but not least, working on reproductive health has involved a substantial amount of literature, leading to the limitations of this study.

The limitation of this approach is that the thesis has not engaged sufficiently with feminist contributions from the Global South, and on the notion of “reproductive rights”. Another significant challenge for this project has been to work with Rohingyas outside the camps. This would have allowed me to collect various materials on life in rural or urban Bangladesh. Besides, the topic is sensitive and dangerous to address, as the government of Bangladesh forbids Rohingyas to live outside the camp area. The original reason for my interest is grounded on the fact that Rohingyas, who are not legally recognised as refugees, seem to find their own solution by living in villages. If similar research is conducted, then it could investigate the questions around the challenges Rohingyas face outside the camps, how they present their identity, how they regularise their status and how they manage to achieve this through informal channels.

Methodologically, I worked with both male and female research assistants who were invaluable. Initially, working with a male assistant did not present any problem, as in that first phase of data collection I was simply gaining a general overview of the camps. The work with female research assistants to explore topics related to reproductive health was crucial both for participating in births, and conducting informal talks, as well as narrative interviews. A one-year ethnographic fieldwork, including informal talks, narrative and expert interviews, as well as participant observations during childbirth have been fundamental to develop confidence with the language, the understanding of life events, and to explore marginal perspectives on the social exclusion of Rohingyas in the field of reproductive health. Self-reflexivity and awareness of my positionality have supported my fieldwork, especially when experiencing a sense of discomfort, similar to what other anthropologists working on childbirth have outlined (Chadwick, 2021; Fitzpatrick, 2022; Jullien, 2019). In the first place, I often felt terrified that something during the deliveries, either at home or in the hospital, could go wrong, as in the case of stillbirths. However, stillbirths have never been mentioned directly by the research participants, who may also have been hiding their fears in this

regard. I have learned to overcome this preoccupation by developing trust in the knowledge of birth attendants and other female relatives, as well as with Rohingyas' ways of approaching life. I have learned the importance of generosity to strengthen new alliances, promoting belief in principles, and protecting other people. I have also experienced substantial discomfort in observing the discriminatory behaviour of some physicians and midwives in their interaction with Rohingyas in the health facilities. While a few of them show empathy for the refugee population, others do not, and I tend to translate this attitude of professionals as a product of governmental policies marginalising the place of refugees in society.

For future research, further investigation could be conducted in refugee camps to examine the implementation of reproductive health and other relevant policies. Research in reproductive health in the Global South has demonstrated the importance of incorporating birth attendants into the health system (I. Ali et al., 2021; Towghi, 2024). I would add that this is also extendable to the studies with refugees and in refugee camps, where institutions are often unable to consider the real needs of women. This is particularly true, especially concerning the perspective of marginalised refugees, whose voices are rarely heard. Like other disadvantaged individuals avoiding health facilities in the South Asian subcontinent, as well as migrants and pregnant women in many other hospitals around the world, Rohingya women's experience is crucial as they decide to give birth in ways that make them feel more protected. Arranging to give birth at home appears to them as a way to navigate social exclusion, and their decision might inspire many other women on a different scale. Home birth appears as a survival strategy for women to protect themselves from the exclusionary attitude of medical personnel inside and outside the camp area.

4. Creating New Life: The *Rosi* and the Umbilical Cord

The *rosi* – i.e., rope - and the burial of the placenta, as well as the umbilical cord constitute important elements in the present work to conclude the analysis of social exclusion during childbirth in Rohingya refugee camps. Despite all the hardship and terror Rohingyas went through first in Myanmar and later in Bangladesh, these women also “endure” for themselves, their children and their families. Their biological, social and cultural survival is achieved. Similarly to Palestinian women's perseverance (*Sumūd*) becoming visible during childbirth (Wick, 2023), Rohingya mothers and *dhoroni* live a culture of creating new life within and despite the life-threatening circumstances in Myanmar, as well as despite structural and systematic social exclusion in the camps of Bangladesh.

Two material elements represent and symbolise this culture. Firstly, the *rosi* or rope that hangs from the ceiling of the shelters offers stability and support for the birth-giving woman. By holding the rope and exerting pressure on it, she is also able to produce a force of counterweight, sustaining her own efforts during labour. At this moment other women are present, physically supporting her with their own bodies and presence. Secondly, the *nar*, the umbilical cord that should be cut at the right moment according to cultural norms (when it is cut too early, it might endanger the life of the newborn) represents protective care, as there is a group of attending women who collect it and place it outside where it will be buried, for sanitary as well as for spiritual reasons.

These two phenomena symbolise the other women's support, and through them, that of the wider refugee community - whether at home or at least sometimes in a hospitalised setting - to give birth despite the overall situation of social exclusion. Finally, they symbolise the trust of the young mother and the other attending women who bury the umbilical cord. The separate burial practice represents the biological, social and spiritual tie between a mother and her child, a bond which deserves care and protection. Ultimately, these two material elements and ties - the *rosi* and the umbilical cord – represent symbols of the birth-giving process and its potential to determine, with Allah's help, the refugee community's perseverance amidst difficult conditions by means of a healthy birth event.

5. Summary of the Thesis: Exclusionary Discourses and Births in the Camps

This thesis begins with fundamental historical premises. The origins and evolution of the term "Rohingya" have acquired prominent space in research that has been traced through its use from the late 18th century to the present day (Chaudhury & Samaddar, 2018; De Mersan, 2019; Leider, 2018; Leider & d'Hubert, 2011; Prasse-Freeman, 2017; Uddin, 2020). The debated origins of the term "Rohingya" mirror the multiplicity of historical facts that have contributed to Rohingya forced migration.

After the British annexed Arakan during the first Anglo-Burmese War (1824-1826) and the rest of Burma during the second and third Anglo-Burmese Wars (1852 and 1885-1886), the Bengali Immigration Scheme was promoted, along with the migration of Indian workers to Arakan (Siok Hwa, 2012). Even before these migration policies, the demography in Arakan appeared to be very diverse, although the colonial authorities could not keep track of the presence of people in the territory through censuses because people used to migrate on a regular basis (Cady, 1960; Charney, 2009; Rahman, 2020; Yegar, 1972). The census had the effect of dividing people according to religion, language and ethnicity (De Mersan,

2019) but without a real understanding of the region. These divisions have been incorporated in later nationalist projects due to the tensions that arose. The role of Burma, described as a “colony within the colony”, acquired significance in the overall partition process in 1937 (Charney, 2009, p. 40), when it was formally separated by British India. In the aftermath, also due to the violence of World War II and the tensions between Buddhist people and Muslims in Arakan, the status of minorities deteriorated in the country (Leider, 2023). The legacy of colonialism, during which Indians had a privileged position, across the end of World War II and the nation-building process, worsened the situation of minorities both in terms of legal regulations for their stay and in the general atmosphere of respectively prevailing public opinion. In this hostile scenario for migrants and minorities, the first Rohingyas fled the country in 1948 and 1959. In this way, migration of people in the region has acquired the characteristic of forced migration.

The term “forced migration” is crucial because of its emphasis on the importance of the overall partition process and nation-building processes, to understand the displacement of people throughout Asia (Banerjee & Samaddar, 2019). The *Naga Min* operation was launched in Arakan in 1978 to verify people’s identity in the region. The violence of this operation led 250,000 people to migrate to Bangladesh, but soon they were returned to Myanmar. The 1982 Citizenship Law, passed in the postcolonial phase in Myanmar acquired a strong nationalist character (Gravers, 2007). With clear elements of chauvinist exclusion, certain minorities were represented as irregular migrants or traitors. The implementation of the citizenship law forced Rohingyas to flee the country in 1991-1992 as they became *de facto* stateless (Cheesman, 2017). Rohingyas fled in masses and were returned in a long process lasting decades. In 2012 and 2016-2017, structural discrimination and escalating violence against the Rohingyas once more caused their mass migration to Bangladesh (Cheesman, 2017; Guhathakurta, 2017; Uddin, 2020). The persecution of Rohingyas has been defined as a “slow-burning genocide” (Zarni & Cowley, 2014), including sexual and gender-based violence, the restriction of their freedom of movement, education and healthcare, as well as the limitation of their reproductive rights based on religion.

The characterisation of Rohingya displacement as a forced migration therefore includes a gendered dimension. From the outset, this has contributed to a general focus in academic contributions to tackle legal aspects and solutions to the Rohingyas’ condition of protracted displacement in Bangladesh and elsewhere. Research has described Bangladesh both as a transit and residence country for Rohingyas. Many Rohingya people have left Bangladesh for other countries, such as the Gulf States, Malaysia, Indonesia, and Thailand (Lewa, 2008;

O'Brien & Hoffstaedter, 2020; Phiri, 2008; Wong & Suan, 2012). Finally, academic contributions on Rohingya migration have emphasised the structural inequalities or social exclusion affecting Rohingyas, as well as their resistance, refusal, coping strategies or survival strategies to navigate the situation of protracted displacement (Farzana, 2016; Prasse-Freeman, 2023; Rahman, 2021). Yet before the present study, no serious attempt was made to specify differences in experiences for Rohingyas in terms of their life in Bangladesh. A few authors have attempted to account for the diversity among Rohingyas (Anwary, 2022), but research could have offered more detailed ethnographic material. This thesis' chapter on the legal analysis has provided a first overview of the discourses that tend to exclude Rohingyas in Asian context. The absence of refugee law in Bangladesh appears as a first layer of social exclusion. Nevertheless, the decision of the majority of Asian countries not to sign the 1951 Geneva Convention *Relating to the Status of Refugees* does not automatically equate to refugees' exclusion (Z. S. Ahmed, 2019; Banerjee, 2014; Chimni, 2009; Davies, 2008; Karatani, 2005; McConnachie, 2014; Moretti, 2021; Vijayaumar, 2001). Various domains of refugee-related law can be explored in Bangladesh (Arif, 2020; Barbour, 2021; Hossain, 2021), like in the contribution made by the Third World Approach to International Law (Chimni, 2009; Kneebone et al., 2024; Tinmaing & Kanji, 2020). Religion, customary law and Court decisions, as well as relevant international treaties and the Constitution of Bangladesh, provide alternative legal resources for Rohingyas living in the country. For example, the *Registration of Births and Deaths Act* formally guarantees the right of Rohingya newborn children to be registered.

In the end, while recognising the importance of legal analysis, and with the use of emic categories more crucial dynamics affecting Rohingyas in Bangladesh can be observed. Significant emic categories for Rohingyas include registered and unregistered refugees, old refugees, new refugees, *qwesha*, *wessa* and *boinga*, terms that are referred to throughout the ethnography. According to emic analysis, for over three decades, a group of the "registered refugees" or old Rohingyas has been confined to two "old camps", while others were repatriated to Myanmar (Crisp, 2018) and then returned to Bangladesh due to continuous human rights violations. In 2017, after the most recent influx of Rohingyas to Bangladesh, thirty-two new camps were opened (ISCG, 2018). The emic terms have provided a base to argue against two historical representations of Rohingya forced migration in Bangladesh. First, Rohingyas' migration has been exclusively addressed in terms of the 1991-1992 and 2016-2017 mass displacements to Bangladesh. In other words, it has been

addressed in terms of “registered refugees” and “unregistered refugees”, as if Rohingyas took shelter in Bangladesh only in the 1990s and in 2017. However, this is not true as smaller influxes of Rohingyas took place in other periods and settled outside the camp area. Second, Rohingya migration has been characterised by cyclical elements – Rohingya departures coincided with forced returns from Bangladesh (Leider, 2020) – but movements on a smaller scale have opposed these cycles. Overall, Bangladesh has adopted an intolerant approach in the newly established camps, where Rohingyas are called “unregistered refugees” (Crisp, 2022; Guhathakurta, 2017; Sengupta, 2018; N. Uddin, 2020). Rohingyas have faced several structural challenges in Bangladesh; this camp ethnography has attempted to show that Rohingyas experience their life in Bangladesh differently according to their age, gender and the camp they live in, while they try to cope with their social exclusion through social ties and the activation of informal resources.

Rohingyas cope with camp restrictions through strategies informed by language skills, local knowledge, and mobility. Life in the camps demands hypermobility to access several humanitarian resources, which are neither always appropriate nor easily distributed. For instance, many pregnant women often need to walk across the entire camp to reach the health facility to give birth. As regards the Rohingyas in the first camp, the informal settlement camp, they face challenges because they have lived in makeshift settlements for years until their settlement has been finally recognised as a camp in 2017. Henceforth, they started looking at their time spent in Bangladesh as a resource. Despite encampment policies, Rohingyas can use local knowledge to cross checkpoints and find informal employment outside the camps. In old camps, collaboration between Rohingyas and locals supports community ties. However, ties with local deviant groups have led to criminal activities, resulting in many families and women being stuck in the camp. Rohingyas in the old camp use their local knowledge as a resource and adjust their way of speaking to mingle into the local population. Overall, these examples highlight the value of the social ties between Rohingyas and local people, as well as the contradictory function of the humanitarian social actors. The people living in the third camp, isolated from others, have been recently affected by the violence in Myanmar, where they have experienced a substantial mobility limitation in Rakhine State. They respect their condition of imposed immobility but rely on the social ties within the camp, both with relatives and neighbours. If their relatives live in other camps, Rohingyas in this camp rather trust “strangers” with whom they share their everyday life because they are part of the same camp. Despite the

differences between the three camps, during my fieldwork, institutions used certificates, ration cards and family data cards, as well as the distribution of resources in the same way to achieve their interests in all camps. Moreover, a general policy has started promoting facility-based births in the camps. Nevertheless, each one of the hospitals has a different approach to dealing with births.

The primary health centre in the informal settlement camp has taken steps forward to support Rohingya pregnant women, employing two Rohingya birth attendants. In the new camp, the hospital has employed Rohingyas mainly as community health workers, aiding pregnant women in reaching health facilities, but without any assisting role given during hospital deliveries. Therefore, pregnant Rohingyas prefer home births, especially after the reduction of funding and the closure of a hospital in the new camp, leading to a group of Rohingya community health workers being fired. Finally, in the old camp, facility-based births have occurred more regularly for a decade, yet the two employed birth attendants are often absent during hospital deliveries. Consequently, to avoid any interaction with midwives and national physicians, almost all pregnant women are accompanied by Rohingya attendants who conduct deliveries without being employed in the hospital of the old camp.

The experiences of Rohingya women giving birth in refugee camps involve fears and preferences regarding the place of birth, as well as their search for emotional and medical support, often provided by the *dhoroni*, to navigate these experiences and give birth as they prefer to. Rohingya women express a profound sense of fear for hospitalised births due to concerns, for instance, about the treatment of the placenta and umbilical cord. They believe that the soul of the baby is in the placenta and the cord should not be cut until the placenta is expelled and the baby manifests signs of life. Another concern is the potential presence of male doctors, as birth is seen as a female domain. Additionally, the majority of Rohingyas are afraid of surgical interventions like episiotomies and Caesarean sections, even when these are necessary. The Rohingyas follow specific cultural practices surrounding birth. They generally prefer to give birth at home, often in a standing position while holding the *rosi*, namely, a cloth hanging from the ceiling for support.

The *dhoroni* provide crucial support to pregnant women, both at home and in hospitals. They act as cultural mediators, helping women navigate the healthcare system, as well as the multiple layers that contribute to the experience of social exclusion. A few *dhoroni* are employed in health facilities, where they sometimes have a complex relationship with Bangladeshi midwives. In all these instances, the body appears as a site of autonomy

for Rohingya women. In a context where they have limited space for choice, their bodies become an instrument as well as a performative stage for them to maintain their cultural practices and exert some control over the birthing process. Due to changing circumstances in the camps and refugees' lives, including their weakened physical condition, hospitalised births are presented as a forced choice in the informal settlement camp. In the old camp, instead, the adaptation for most women to cope with medicalised births is to have a *dhoroni* accompany them and assist with their deliveries in the hospital. In the new camp, survival strategies are pursued to give birth in the pregnant woman's shelter. *Šude ārar šorillan ārar fūwati asede*, "our bodies are the only things left to us", the *dhoroni* Fatima once told me this sentence, and indirectly suggested to me that analysing Rohingya women's bodies and how they are perceived is a key to grasp women's social exclusion, as well as their various strategies to navigate childbirth in refugee camps.

Epilogue

Two years ago, I left southeastern Bangladesh, where I accomplished a one-year fieldwork. It was November 2022 when the humanitarian response on the island of Bhasan Char had just consistently started: around 30,000 Rohingyas were resettled from the refugee camps to this empty island (UNHCR, 2022). In contrast, donations had been considerably reduced in the same year for the rest of the Rohingya humanitarian response due to the shift in the global geopolitical scenario after Russia's invasion of Ukraine, which soon became torn by war (International Crisis Group, 2023). The reduction of humanitarian aid in the camps was, in fact, visible by the fact that food rations have recently diminished from US\$ 12 per month per capita to US\$ 8 (WFP, 2023b).

Just one month after the end of my fieldwork, in December 2022, the U.S. government announced the launch of resettlement programmes for Rohingyas in Bangladesh to be accomplished by the government of Bangladesh and the United Nations High Commissioner for Refugees (Fortify Rights, 2022). Later, in June 2023, the government of Myanmar proclaimed the replacement of the 1982 Citizenship Law which denied Rohingyas access to citizenship rights (Fortify Rights, 2023a). Overall, it seemed that for Rohingyas, their future perspectives started improving in 2023. Nevertheless, already in the first months of 2024, around 300 "Rohingyas" were beaten and pushed back by the Bangladeshi border guard because the government closed its borders to them (Fortify Rights, 2024a). Earlier in February 2024, Fortify Rights reported that almost 300 members of the Myanmar Border Guard Police (BGP) fled into Bangladesh from clashes with the Arakan army. Due to their possible involvement in atrocious crimes in Myanmar, the government of Bangladesh launched coordinated activities with the International Criminal Court (Fortify Rights, 2024c). In addition to the uncertainty of this situation, an ever-growing number of Rohingyas were forcefully enlisted in the national army in Myanmar. In April 2024, many Rohingyas were forced to the frontline in Myanmar after a new conscription scheme in the country of origin (Zaw, 2024). The escalation of violence in Myanmar has forced 80,000 Rohingyas to take shelter in Bangladesh (The Daily Star, 2025). The halt of USAID funding in the refugee camps in 2025 has had ever impacts on Rohingyas' lives (RO Maung, 2025).

I have also kept in touch with some individuals who were not directly involved in my fieldwork. The majority of the research participants, however, did not own a smartphone so it was impossible to keep in touch. As I kept studying the language, I regularly talked to my

Rohingya language teacher. In 2024, the Rohingya teacher's father was requested to pay BDT 100,000 by a terrorist organisation in the camps, the Arakan Rohingya Salvation Army, ARSA. He refused to do so and for BDT 50,000 he moved to another shelter next to the main road and near some of the camp offices so that he could live in a safer place. His son asked him to move to a village in Cox's Bazar area, but he declined the offer. The topic of discussion about whether to live in the surrounding villages or in the camps was already a vibrant debate between Rohingyas from different generations, as highlighted by the Rohingya writer Mayyu Ali in his book (M. Ali & Lopes, 2022), and kept being a hot topic among Rohingyas, since living conditions in the camps have worsened so far. In a nutshell, my teacher, in his 30s, tries to navigate life in a Bangladeshi village while building his own family, while his 60-year-old father, who has been living with other Rohingyas in the camps for the last seven years, does not want to move to a village outside the camp area.

In the summer of 2024, a group of Bangladeshi students started demonstrating against a quota established by the government and confirmed by the Bangladeshi Constitutional Court, that allocated 30% of governmental positions to the successors of the liberty fathers who fought the war of independence in 1970 and 1971 (Battiston, 2024). The growth of these protests led to the collapse of Sheik Hasina's government, and the prime minister had to fly to India - after her attempts to violently repress the demonstrations had failed. The Bangladeshi people I kept in touch with during the year 2024 all seemed sceptical about this shift in power. Despite their opinions, my own point of view is substantially influenced by how Rohingyas' conditions in the country are affected.

Several Rohingyas were pushed back under the new interim government (Human Rights Watch, 2024b; Paul, 2024) - led by the Nobel prize holder Mohammad Yunus. When Hasina was in power (2009-2024), some had denounced the fact that under her regime Rohingyas had been beaten and forcibly returned (Fortify Rights, 2024a), as well as illegitimately arrested, although she kept a general level of stability in the region by looking after the international relations with China, India and Myanmar. In comparison to the Muslim majority of Rohingyas, the prospects of the minorities, like the Hindus or Christians, were not and are still not promising. The regional and geopolitical stability guaranteed during Hasina's rule was paid at the price of systematic episodes of violence that targeted minorities and refugees in the country, but this was rarely addressed publicly.

It is too early to evaluate the current governmental policies towards the Rohingyas after this massive political change of regime in 2024, and the instability in Myanmar. Unfortunately, however, Rohingyas' condition seems to have deteriorated since August

2024, especially after the exacerbation of local and national tensions in Rakhine State (Burmese Rohingya Organisation UK, 2024; Global Centre for the Responsibility to Protect, 2024; Human Rights Watch, 2024a). According to the *Asia-Pacific Migration Report 2024*, the Rohingyas are the largest displaced stateless people in the world; more than 970,000 live in Bangladesh, whereas around 150,000 are internally displaced in Myanmar (ESCAP, 2024, p. 62).

List of Rohingya expressions & terms

Asor bisor: the vision of demons

Ay: I (first-person singular pronoun)

Balti: bucket

Bezati: foreigner; outsider from an ethnic group

Bideci: foreigner

Boidyo: traditional healer

Dadi: paternal grandmother

Daima: birth attendant; midwife

Desh: country

Dhoroni: birth attendant, puller

Dholu: thin and sharp external part of bamboo

Ferein: people with light skin pigmentation; white people

Fojor/fozor: morning

Jol: placenta

Furan: old

Fuwa dhoroni: birth attendant, child puller

Ga: body

Gusol: bath for menstruation

Harha: to cut

Hasor: afternoon

Heshar/eshar: night

Juhur/zuhur: late morning

Khala: aunt

Majhi: captain; leader

Moghorib: sunset

Moktob: Quranic kindergarten

Moy: I (first-person singular pronoun; mainly used among people from Maungdaw)

Jaighir deowa: homestay in a host family to pursue education or work in another city

Mura: mountain; hill

Naghi: navel

Nar: umbilical cord

Ooin: fire

Rosi: rope

Šoril: body

Tel: to push

Zwar: high tide

List of acronyms

AL: Awami League

ANC: Antenatal care

ARSO: Arakan Rohingya Salvation Army

ASEAN: Association of Southeast Asian Nations

BDT: Bangladeshi taka, the currency of Bangladesh

BGP: Myanmar Border Guard Police

BNP: Bangladesh Nationalist Part

BSPP: Burma Socialist Programme Party

CARE: Cooperative for Assistance and Relief Everywhere

CAT: *Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment*

CEDAW: *Convention on the Elimination of All Forms of Discrimination against Women* or

CERD: *International Convention on the Elimination of All Forms of Racial Discrimination*

CHW: Community health workers

CIC: “Camp in Charge” person

CMEC: China–Myanmar Economic Corridor

CMW: *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*

CNG: Compressed Natural Gas

CPA: *Comprehensive Plan of Action*

CRC: *Convention on the Rights of the Child*

CRPD: *Convention on the Rights of Persons with Disabilities*

CSC: Citizenship Scrutiny Cards

EFEO: École Française d’Extrême Orient

EPG: *Eminent Persons Group for South Asia*

ESCAP: Economic and Social Commission for Asia and the Pacific

FDMN: Forcibly displaced Myanmar nationals

GK: *Gonoshasthaya Kendra*

ICCPR: *International Covenant on Civil and Political Rights*

INALCO: *Institut National des Langues et Civilisations Orientales*

IOM: International Organisation for Migration

ISCG: Inter-Sector Coordination Group

JPR: Joint Response Plan
MISP: Minimum Initial Service Package
MSF: Médecins Sans Frontières
NGO: Non-Governmental Organisation
NRC: National registration cards
OSCE: Organisation for Security and Co-operation in Europe
RMMRU: *Refugee and Migratory Movements Research Unit*
RRRC: Refugee relief and repatriation commissioner
RSD: Refugee status determination
RTMI: Research, Training and Management International
SAARC: South Asian Association for Regional Cooperation
SEZ: Special Economic Zone
SLORC: State Law and Order Restoration Council
SMS: Site management support
TBA: Traditional birth attendant
TWAIL: Third World Approach of International Law
UN: United Nations
UNFPA: United Nations Population Fund (originally United Nations Fund for Population Activities)
UNHCR: United Nations High Commissioner for Refugees
USAID: U.S. Agency for International Development
WFP: World Food Programme
WHO: World Health Organisation

Annex I: Extension of the Refugee Relief and Repatriation Commissioner's permission and related research conditions

Government of the People's Republic of Bangladesh
Office of the Refugee Relief and Repatriation Commissioner
Cox's Bazar
www.rrrc.gov.bd

No: 51.04.2200.009.16.011.22.3694

Date: 04 August 2022

Sub: Extension permission for research work in Rohingya Camps.

Ref: 1. Letter from Ms. [REDACTED] Student, Ph.D, University of Vienna, Austria,
Dated: 26 July 2022

2. Letter No- 51.04.2200.009.16.008.22.2037 of this office, Dated: 18 May 2022

In response to the above mentioned letter, this office is pleased to grant your proposal for the extension of permission to do research work in Rohingya Camp area in Cox's till- 30 September 2022 under the following terms and conditions.

1. You are requested to inform before commencing the activities and coordinate while working, with the concerned CiC (Camp-in-Charge);
2. Must follow Govt. Policy, Rules and Laws;
3. Maintain COVID-19 preventive measures;
4. The content/report must be submitted to RRRC office as well as to CiC office, before publishing;
5. The part related to the relation of FDMN community among Bangladeshi community should be removed from the Questionnaire.
6. You are not allowed to enter the FDMN Camps during Government Holidays.
7. You must leave the Camps before 3.30 pm.

Please feel free to contact with office if you have any further query.

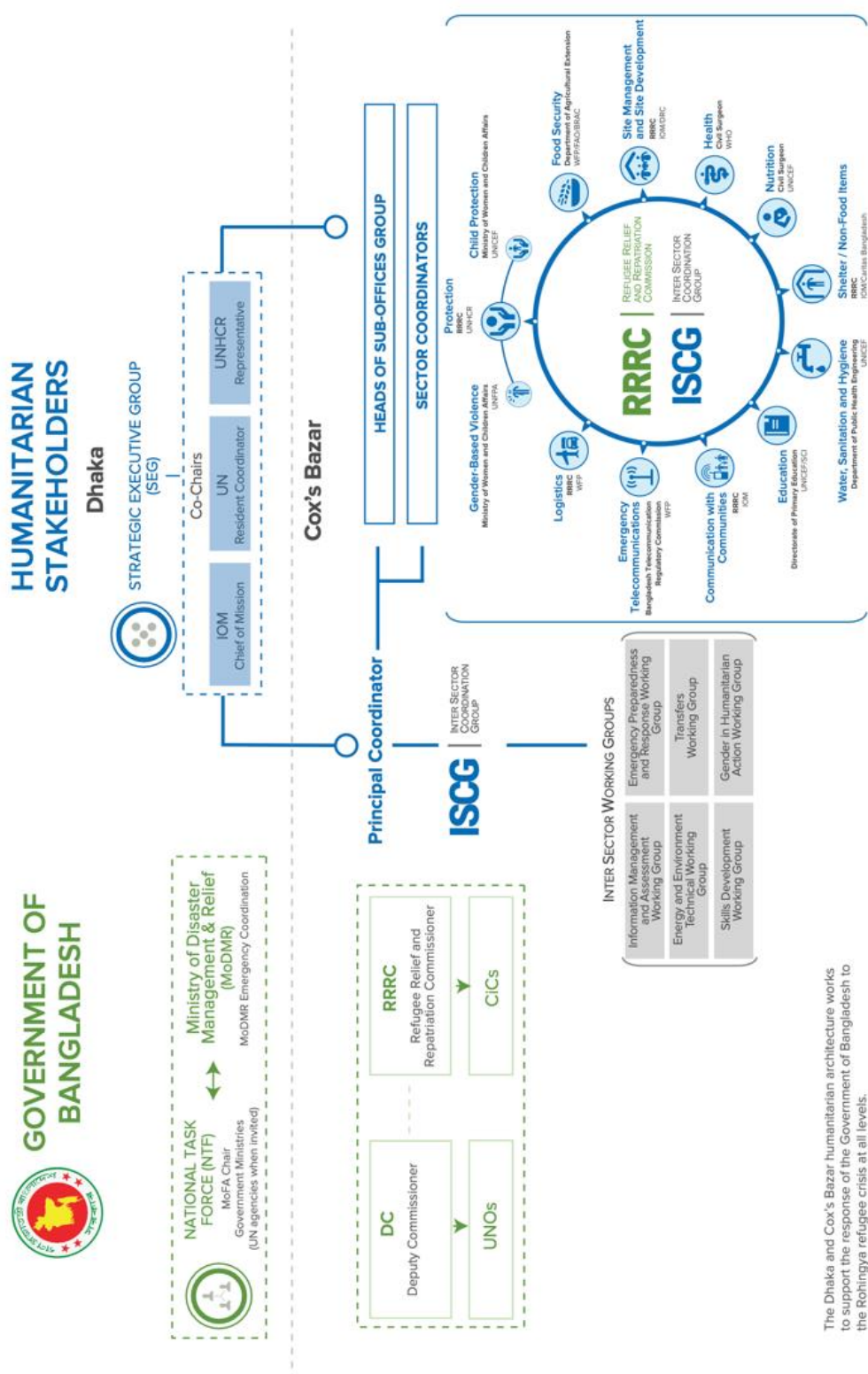
[REDACTED]
[REDACTED]
Senior Assistant Secretary (NGO)
Phone: 01847-351673
Email: contact@rrrc.gov.bd

[REDACTED]
Student, Ph.D
University of Vienna, Austria
Email: [REDACTED]

Copy for Information and necessary action:

01. Camp-in-Charge Camp- [REDACTED] Cox's Bazar
02. Office Copy

Annex II: Graph illustrating the coordination mechanisms for the Rohingya humanitarian response ISCG (2022, p. 17).



The Dhaka and Cox's Bazar humanitarian architecture works to support the response of the Government of Bangladesh to the Rohingya refugee crisis at all levels.

Annex III: List of birth attendants or *fuwa dhoroni* who took part in this research

Name	Role	Camp	Years in BD	Age
Rubina	CHW	Informal Settlement Camp	25	40-50
Amina	TBA	Informal Settlement Camp	10	50-60
Naslima	TBA	Informal Settlement Camp	12	40-50
Fatima	<i>Dhoroni</i>	New Camp	5	50-60
Aicha	<i>Dhoroni</i> (ex-CHW)	New Camp	5	40
Sufia	<i>Dhoroni</i> (ex-TBA)	Old Camp	30	60
Moriam	<i>Dhoroni</i> (ex-TBA)	Old Camp	30	50-60

List of maps and illustrations

Image 1: Map of Cox's Bazar district.	27
Image 2: The first map of Bangladesh shows Southern Chittagong. The second map shows the region and in four red frames cluster no. 1 of camps (Kutupalong and another area, called Balukhali), camp areas no. 2, 3 and 4 (Nayapara area).	37
Image 3: A board at the international border with India (van Schendel, 2005, p. 191).	51
Image 4: The buoy demarcating the border on the river Naf between Bangladesh and Myanmar. (van Schendel, 2005, p. 335).	51
Image 5: Map of Rakhine State, Myanmar.	54
Image 6: Page 89 of published chapter (Grillo, 2025).	92
Image 7: Page 90 of published chapter (Grillo, 2025).	93
Image 8: page 91 of published chapter (Grillo, 2025).	94
Image 9: Page 92 of published chapter (Grillo, 2025).	95
Image 10: Page 93 of published chapter (Grillo, 2025).	96
Image 11: Page 94 of published chapter (Grillo, 2025).	97
Image 12: Page 95 of published chapter (Grillo, 2025).	98
Image 13: Page 96 of published chapter (Grillo, 2025).	99
Image 14: Page 97 of published chapter (Grillo, 2025).	100
Image 15: Page 98 of published chapter (Grillo, 2025).	101
Image 16: Page 99 of published chapter (Grillo, 2025).	102
Image 17: Page 100 of published chapter (Grillo, 2025).	103
Image 18: Page 101 of published chapter (Grillo, 2025).	104
Image 19: Page 102 of published chapter (Grillo, 2025).	105
Image 20: Page 103 of published chapter (Grillo, 2025).	106
Image 21: Page 104 of published chapter (Grillo, 2025).	107
Image 22: Page 105 of published chapter (Grillo, 2025).	108
Image 23: Page 106 of published chapter (Grillo, 2025).	109
Image 24: Page 107 of published chapter (Grillo, 2025).	110
Image 25: Page 108 of published chapter (Grillo, 2025).	111
Image 26: Page 109 of published chapter (Grillo, 2025).	112
Image 27: Page 110 of published chapter (Grillo, 2025).	113
Image 28: Page 111 of published chapter (Grillo, 2025).	114

Image 29: A replica of the community health worker, Rubina walking through her block to visit pregnant women in their shelters.	121
Image 30: A replica of a family data card.	126
Image 31: Roshida showing me her family data card.	127
Image 32: The clinical manager and the camp-in-charge person must sign this birth certificate form for facility-based births to have a birth certificate issued.	130
Image 33: The community health worker, Rubina explains family planning methods to a group of Rohingyas during a block meeting.	133
Image 34: A representation of the dhoroni Aicha, assisting a woman in giving birth at home during the night.	155
Image 35: “Basic principles of Antenatal care and Hygienic delivery” certificate.	173
Image 36: Reference letter confirming Sufia’s work for Save the Children as “traditional birth attendant” between 1993 and 1997.	174
Image 37: “HIV/AIDS prevention and awareness” certificate.	175
Image 38: A drawing of the <i>dhoroni</i> , Moriam sitting in her living room.	180
Image 39: হাঁড়ি, harhi, earthenware pots, containing yoghurt, and often used to bury the placenta.	216

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