Nationalities SERVICE CENTER

Caring for the Health of Refugees and Immigrants with Disabilities

Rohingya of Myanmar

Population of Myanmar: 52.89 million (2016 estimate)

The Rohingya are an indigenous ethnic minority that reside in the Rakhine state of western Myanmar. While the Rohingya are native to this area, Burmese propaganda has spread misinformation that the Rohingya are Bengali migrants. Muslim Rohingya are outnumbered in the Rakhine state by Rakhine Buddhists, and sectarian violence between these two groups began in 2012 after several Rohingya men were wrongly accused of raping a Buddhist woman. The government of Myanmar denies Rohingya citizenship and excluded them from the 2014 census.

In August 2017, the military took action against the Rohingya after the Rohingya ARSA group attacked several security officers. Following the attacks, Buddhist mobs went door to door and murdered at least 6,700 Rohingya. At least 288 Rohingya villages were completely destroyed. Members of the international community have said that the Rohingya are facing genocide, however the government of Myanmar refuses to acknowledge any of the atrocities that have been committed. Many Rohingya fled to Bangladesh and Malaysia. Refugees have not been welcome in Bangladesh, and the Bengali government has tried to send the Rohingya back to Myanmar.

Disability in Myanmar

Stigma: Older adults and persons with disabilities living in refugee camps have skills and knowledge that go unrecognized or underutilized by other camp residents and service providers. These issues stem from negative stereotypes and stigmas about disabilities and limit them from contributing to their communities. People with disabilities report exclusion from their communities and lack of access to education.

Education: Compared to children without disabilities, adolescents ages 15-19 years with disabilities are 10 times as likely to be illiterate. In Myanmar, 44% of disabled who are 13 years old have never attended school. However, in Bangladeshi refugee camps, only 45% of all children are able to go to school. Rohingya children have been expelled from Bangladeshi schools and Rohingya children with disabilities have reported that they have not been allowed to attend school or socialize in child-friendly spaces because of their disability. In Myanmar, there are very limited special education services available and they are only provided in certain states. Because of this, individuals with disabilities are very unlikely to have received specialized services in school in the Rakhine state.

Services: Within Rohingya refugee camps there are no developmental pediatricians and therefore, children are unable to get diagnosed or receive proper medical treatment. Parents in refugee camps who do seek services for their children with disabilities typically will go to the shaman who will use traditional healing methods to treat disability. Humanitarian International has a program in Rohingya camps called “PlayTogether”, which encourages children of all abilities to play together to help children with disabilities develop social skills. This is the main service available in camps. Some rehabilitation, occupational therapy, and health intervention services are available in Myanmar, however these are scarce in the Rakhine state where the Rohingya reside. There are also limited vocational training programs available in Myanmar, but these are also scarce in the Rakhine state.

Rohingya is its own language, and the majority of the Rohingya practice Islam. In the map below, the orange portion indicates where the Rohinhya crisis is taking place.

Health Beliefs: Rohingya refugees may have received little to no medical care before arrival. Refugees may hold medical beliefs that are not similar to U.S. beliefs. One example is a belief that good health results from the right balance of "hot" and "cold" elements, and if the body is unbalanced it can result in poor health. Those newly arrived to the U.S. have limited exposure to Western medicine. Preventative screenings such as pap smears, mammograms, and colonoscopies can be unfamiliar to this refugee population.

Mental Health: Many refugees are not familiar with Western views of mental illness and the treatment options in the United States. Some people believe that those struggling with mental illness should remain stoic, turn to religion for treatment, or bear problems without complaint. Myanmar has few psychiatric hospitals, and mental health services in refugee camps are limited. Individuals who have mental illnesses that prevent them from working are typically cared for by their family. Epilepsy is viewed as a form of mental illness. It is also important to understand that many Rohingya refugees have experienced and witnessed violent and traumatic events.

Gender Roles: Rohingya women are typically expected to stay inside the home to do housework and take care of children. In refugee camps it is typically seen as the man's job to go out to get water and food. Women typically have little to no education about reproductive health and usually do not have access to any form of contraception in refugee camps. Many women have also been targets of sexual violence in the Rakhine state and in refugee camps.

Notes for Providers when Working with Refugees and Immigrants with Disabilities

The United Nations states, "*a disability is a condition or function judged to be significantly impaired relative to the usual standard of an individual of their group. The term is often used to refer to individual functioning, including physical, sensory, cognitive, and intellectual impairments, mental illness, and various types of chronic disease.*"

People with disabilities are more likely to experience poorer health, fewer economic opportunities, and higher poverty compared to people without disabilities. Many individuals with disabilities lack equal access to healthcare, education, and necessary disability-related services. These factors are primarily due to lack of resources including services, transportation, information, and technology. Persons with disabilities face barriers in the forms of the physical environment, legislation and policy, societal attitudes, and discrimination. Evidence has shown when those barriers are lifted, individuals are more empowered to participate in their society, which thereby benefits the entire community. Fifteen percent of the world's population has some form of a disability, with eighty percent of persons with a disability living in developing countries (UN).

According to the Women's Refugee Commission, of the 68.5 million people displaced worldwide, there are 13 million displaced persons with disabilities. Refugees are one of the most vulnerable and isolated groups of all displaced persons. Because of physical and social barriers, stigma, and attitudes, many individuals with disabilities are often excluded from mainstream assistance programs. During displacement, refugees with disabilities experience more isolation than when they were in their home communities.

Refugees and immigrants with disabilities are entering the United States with many unmet disability-related needs. There exists much disconnect between refugees and immigrants and disability service systems. These barriers are present because of mistrust between the different service entities and lack of cross-cultural nuance among disability service organizations. These findings contribute important insights to the literature on disability disparities.

The U.S. healthcare system is complex and can be difficult to understand and navigate, especially for a refugee or immigrant coming from a country with limited healthcare services. Because resettlement services are time limited, it is important for care providers to work with other professionals to coordinate care for persons with disabilities. To best serve refugees with disabilities, providers need to consider the client's history, life and experience in the country of origin or host country, and cultural perceptions of disability.

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