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Humanitarian Crises and Mental Health Coping Strategies Among Myanmar Refugees in Mizoram State, India

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Correspondence: Tual Sawm Khai (ktuals@polyu.edu.hk)**Received:** 22 April 2025 | **Revised:** 5 January 2026 | **Accepted:** 5 January 2026**Keywords:** COVID-19 | health services | humanitarian | India | military coup | Myanmar | refugees and asylum seekers

ABSTRACT

The Myanmar military coup in February 2021 exacerbated the existing severe humanitarian crisis, resulting in the displacement of over 3.5 million civilians as of June 2025. Additionally, 78,731 individuals sought asylum in neighboring India as of 2023, fleeing the persecution and armed conflict in their homeland. This qualitative study examines the lived experiences and coping mechanisms of Myanmar refugees in Mizoram, India, after the 2021 coup through interviews with camp leaders, refugees and camp helpers. This study findings highlight the challenges faced by displaced populations, including insufficient humanitarian assistance for basic needs, restricted livelihood opportunities, and barriers to accessing healthcare have worsened their psychological distress and well-being. This study findings also revealed that due to lack of formal mental health support in refugee camps, refugees have to rely on religious coping strategies and communal gatherings as resilience mechanisms. This research findings underscore the need for structured humanitarian interventions, including the enhanced provision of essential services, COVID-19 vaccination programs, and psychosocial support for displaced Myanmar populations in Mizoram. This study contributes to the refugee welfare discourse in conflict-induced displacement settings by highlighting the role of international and local aid agencies in addressing asylum seekers' vulnerabilities.

1 | Introduction

The global displacement crisis has escalated, with a significant number of individuals being forced to flee their homes because of conflicts, persecution, and other crises. In 2023, over 117.3 million individuals across the globe were forcibly displaced due to persecution, armed conflict, violence, breaches of human rights, and disruptive events that undermined public order. The number of refugees has reached 43 million and is hosted in neighboring countries, with approximately 69% residing in low- and middle-income countries (UNHCR 2024). Across the globe, individuals seeking asylum and refugees encounter numerous difficulties in their host countries. These include societal discrimination and restricted access to education, healthcare, housing, and employment (Khai 2025; McIntyre and Hall 2020;

Song and Teichholtz 2019; Szaflarski and Bauldry 2019; Ziersch et al. 2020).

In Myanmar, the military coup in February 2021 intensified armed conflicts, leading to increased displacement and vulnerability among IDPs who experienced daily anxiety and fear, thereby affecting their mental health and well-being (Khai 2022, 2023). Meanwhile, the Covid 19 pandemic has already undermined the public safety and livelihood security of the Myanmar people (Sabhita Kusuma 2023). As of March 2025, more than 3.5 million civilians in Myanmar have been internally displaced (OHCHR 2025), marking a significant increase from 2.7 million displaced in March 2024 since the coup in 2021 (OCHA 2024). This has resulted in many individuals fleeing the country to seek asylum in neighboring nations, particularly in India, Thailand,

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and Malaysia. The people in India-Myanmar borderlands have experienced unsafe and challenging situations owing to military human rights violations and indiscriminate attacks on civilians. As of 2023, India has been home to more than 78,731 refugees from Myanmar since the military coup (Operational Data Portal 2024). In Mizoram State of India alone, over 40,000 individuals were accommodated, whereas in Manipur State of India host more than 8250 refugees (UNHCR 2023). This number appears to have risen significantly because of the ongoing and intense conflicts in Myanmar.

The Indian government has not ratified the 1951 Refugee Convention or its 1967 Protocol. Therefore, Myanmar refugees has not been classified as “refugees” and instead labeled them as “illegal migrants.” In response to Myanmar refugees, India’s Ministry of Home Affairs instructed the states of Arunachal Pradesh, Manipur, Mizoram, and Nagaland to take “appropriate measures” to stop the inflow of Myanmar refugees from the neighboring Chin State in Myanmar (Mint 2021). Furthermore, the Indian government directed state governments, particularly Mizoram and Manipur, to secure the borders and repatriate those who fled the war-torn in Myanmar (Nikkei Asian Review 2024). This has led to a ban on the entry of Myanmar refugees into India and has shown scant regard for the protection of asylum seekers’ rights in India. However, Mizoram Chief Minister Zoramthanga urged Prime Minister Narendra to express that the situation in Myanmar constitutes a “human catastrophe of gigantic proportions” and urged the Indian government to intervene and allow political asylum for the refugees. He emphasized that most Myanmar refugees are of Chin ethnicity, inhabit the areas of Myanmar bordering Mizoram, and are ethnically related to the Mizo in Mizoram. He stated that Mizoram could not remain indifferent to their suffering and that India should not turn a blind eye to their plight (Kaushik 2021). Therefore, the Mizoram state government opted not to close the border with Myanmar refugees and instead proposed the establishment of approximately 160 temporary refugee camps in border regions, as many refugees came from Chin communities who had ethnic ties with Mizo people (Hazarika 2023; Karmakar 2024). The Mizoram state government and local NGOs have supplied Myanmar refugees with necessities such as food, blankets, and other essential items to fulfill their basic needs and allow refugee children to access education and healthcare in public hospitals during the early stages of resettlement (Hazarika 2023). However, the Mizoram State government already faced a significant challenge in continuing to support Myanmar refugees, as it lacked central government humanitarian assistance and had limited state resources after 4 years of military coup and ongoing conflict in Myanmar. This presents significant challenges for Myanmar refugees, who have limited access to humanitarian aid and primary healthcare facilities (Khai 2024).

Moreover, some studies have examined Myanmar refugees in Malaysia and Thailand (Khai and Asaduzzaman 2023; Khai 2025), particularly the Rohingya population in Bangladesh (Islam and Nuzhath 2018; Islam and Yunus 2020), and India (Dutt Tiwari et al. 2024; Nair 2022) have already attracted significant global attention. However, there is a lack of empirical research on Myanmar refugees in India who fled war-torn following the 2021 military coup in Myanmar. Thus, this study investigated the experiences and coping mechanisms of Myanmar

refugees in Mizoram State in India, to offer practical policy recommendations for humanitarian aid delivery and enhancing their health and well-being.

1.1 | Research Questions

1. What are the primary challenges faced by Myanmar refugees and asylum seekers in Mizoram, India?
2. How do they affect mental health and well-being? How do they cope with the challenges they face?

2 | Research Methodology

2.1 | Sampling and Data Collection Process

This study employed a qualitative research design, utilizing in-depth interviews to gather insights from Myanmar refugees and refugee camp leaders in Mizoram State, India. Unlike the formally recognized refugee camps in other regions globally, Myanmar refugees camps are constructed informally along the border between Myanmar and Mizoram State of India. They lack recognition and support from the central government, receiving assistance only from the local government of Mizoram State because of shared ethnic and historical ties that predate India’s independence. These camps are constructed by the refugees themselves, using local materials such as bamboo and banana leaves, often lacking proper roofing, and are situated in isolated, hilly, and forested areas far from urban centers. The mountainous terrain of Mizoram, combined with the underdeveloped digital infrastructure in refugee camps, posed significant challenges for remote data collection, as many camps lacked reliable internet access. In addition to logistical and infrastructural challenges, each camp has its own policy regarding who is allowed to speak with researchers or outsiders because of concerns about the safety and security of its members.

Participants were selected using a combination of purposive and snowball sampling techniques to ensure the inclusion of key stakeholders, such as camp administrators, displaced individuals, and support staff. Initially, the researcher enlisted the assistance of a local researcher who concurrently investigated food security issues in the refugee camps. Through the local researcher assistant and the snowball sampling method, potential participants were recruited and allowed to travel to higher elevations, such as nearby towns, to secure mobile signals or Internet connectivity. The research included six participants, including leaders of refugee camps, volunteer workers, and a refugee, who either represent the camp or have the authority to speak on its behalf. Interviews were carried out remotely using Zoom and WhatsApp from June to July 2023 (see Table 1 for comprehensive participant profiles) and were completed once data saturation was reached. Some participants expressed a preference for WhatsApp over Zoom because of either a lack of familiarity or technical limitations. To mitigate privacy concerns, WhatsApp’s end-to-end encryption feature was utilized to ensure the confidentiality and security of all transmitted data. The researcher interviewed only refugee camps that voluntarily agreed to participate and adhered to the guidelines outlined by

TABLE 1 | Social demographic profile and characteristics of the participants from refugee camps.

Position	Age	Gender	Method of interview	Name of refugee camp	Household	Number of schooling children	Health clinic availability	COVID-19 vaccination	Population in refugee camp
Camp leader	48	Female	WhatsApp	Tuirial Camp, Aizawl District	23	25	Yes	No	78
Camp leader	39	Male	Zoom	Siaha Camp	N/A	62	No	No	205
				SaTial Camp	N/A	16	No	No	29
				Thi Piang Camp	40	74	No	NO	227
Camp Helper	31	Female	Zoom	Zokhawthar District	860	N	No	No	4236
Refugee woman	32	Female	WhatsApp	Zokhawthar District	N/A	N/A	No	No	N/A
Camp leader	34	Male	Zoom	Lawngtlai District	N/A	N/A	Yes, refugee-led clinic	No	N/A
Camp leader	36	Male	WhatsApp	Saiha, India District	N/A	N/A	Yes, refugee-led clinic	Yes, partially	Over 800

Note: N/A refers to no data available. Each refugee camp has its own data privacy policies, and some refugee camp leaders do not have the authority to share or disclose the decisions of their refugee camps.

Braun and Clarke (2006). During the interviews, the researcher took notes and recorded the conversations in audio form. Each interview lasted approximately 20–35 min on average and was recorded in its entirety. The researcher stopped conducting the interviews once saturation was achieved following the qualitative research guidelines (Saunders et al. 2018). As some participants were not proficient in Myanmar language, interviews were also conducted in Falam and Hakha dialects. This study followed (COnsolidated Criteria for REporting Qualitative Research) Checklist.

2.2 | Ethical Consideration

Before conducting the interviews, the researcher outlined the study's objectives and interview process, emphasizing the participants' right to withdraw at any time without obligation. As part of the procedure, written and verbal consent was obtained from the participants, respecting their preferences for both participation and audio recording of the interviews. The researcher assured them that their personal information would remain confidential and would be used under pseudonyms only. Given the logistical limitations and socioeconomic and geographical difficulties faced by the participants, each interviewee was offered a financial reimbursement of 1000 Indian Rupees (INR) to assist with their Internet and transportation expenses. Compensation was provided after the interviews were completed. The research ethics protocol was approved by the Research Ethics Subcommittee of the Postgraduate Student Committee (PSC) at Lingnan University, Hong Kong.

2.3 | Data Analysis

Reflective thematic analysis, an interpretative and analytical process, was used to identify themes within the data. This requires a thorough examination and reflective engagement with the data. To familiarize themselves with the material, the researcher repeatedly listened to the audio recordings and reviewed the notes before transcribing them. Once the audio interviews were transcribed verbatim, they were translated into English. To ensure accuracy, the researcher meticulously compared the transcripts with the audio recordings by reading and replaying them several times. The interviews were transcribed verbatim in English and checked against the audio recordings to ensure precision. After validating and verifying the data, the researcher meticulously examined the transcripts and assigned initial codes to segments containing significant information. Subsequently, the researcher conducted a thematic analysis of the coded data by consolidating similar elements into cohesive themes.

3 | Findings

3.1 | Social Demographic Profile and Characteristics of the Participants

Six participants were interviewed, including four leaders of refugee camps, one refugee, and one camp helper. Participants were selected based on geographical considerations, focusing on regions with a substantial population of Myanmar refugees,

as recommended by local researchers and various documented media sources. The districts selected for this investigation were Saiha, Lawngtlai, Zokhawthar, and Aizawl, which are situated in the Mizoram State of India. Among the participants, three were female, while most of the camp leaders were male (Table 1). A summary of the principal findings is shown in Figure 1.

3.2 | Three Basic Needs: Food, Shelter, and Clothing

Myanmar refugees in India are individuals who have fled conflict-ridden conditions in their native land, specifically from the Chin State and Sagaing Region of Myanmar. These individuals left behind all their possessions, escaping to refugee camps with wearing only the clothes on their backs. They had no saving funds for living expenses, time to pack and preparation for their needs in refugee camps. The military's actions, including the burning of villages, forced them to flee immediately on foot to save their lives until they secured transportation across the borders.

Upon arriving in Mizoram State of India, they encountered numerous challenges, with food insecurity being the primary concern, as reported by the Myanmar refugee communities. The Mizoram State Government established a Village-Level Committee on Myanmar Refugees (VLCMR), comprising members of the Young Mizo Association (YMA) and various non-governmental organizations to provide humanitarian assistance in collaboration with the Mizoram State government. However, not all camps have access to aid, and the humanitarian aid situation is worsened with each passing day owing to the prolonged conflict in Myanmar. A refugee camp leader from Zokhawthar District, Tuirial Camp, Aizawl District, and Saiha District reported receiving emergency humanitarian aid, such as rice and other necessities, from local governments, communities, and NGOs, including ActionAid, ADRA, and the Myanmar Refugee Relief Committee (MRRC) during the initial 3 months of their arrival. Nevertheless, several NGOs and community support systems are no longer available to them because of the passage of over 3 years and the large refugee population in the country. Since 2023, Myanmar refugees have experienced a reduction in humanitarian assistance from NGOs, including essential items such as rice, eggs, and oil to meet their daily needs.

Upon our arrival, the local community generously provided emergency response items, including food and second-hand clothing. However, given the substantial number of refugees, it is understandable that they are unable to sustain adequate assistance over time.

(Saiha, India District, Camp leader and a volunteer teacher, 36-year, Male).

Additionally, the leaders of refugee camps in the Lawngtlai District highlighted the significant shortage of support from NGOs. Although these organizations frequently claim to be actively assisting refugees in the area, their actual presence on

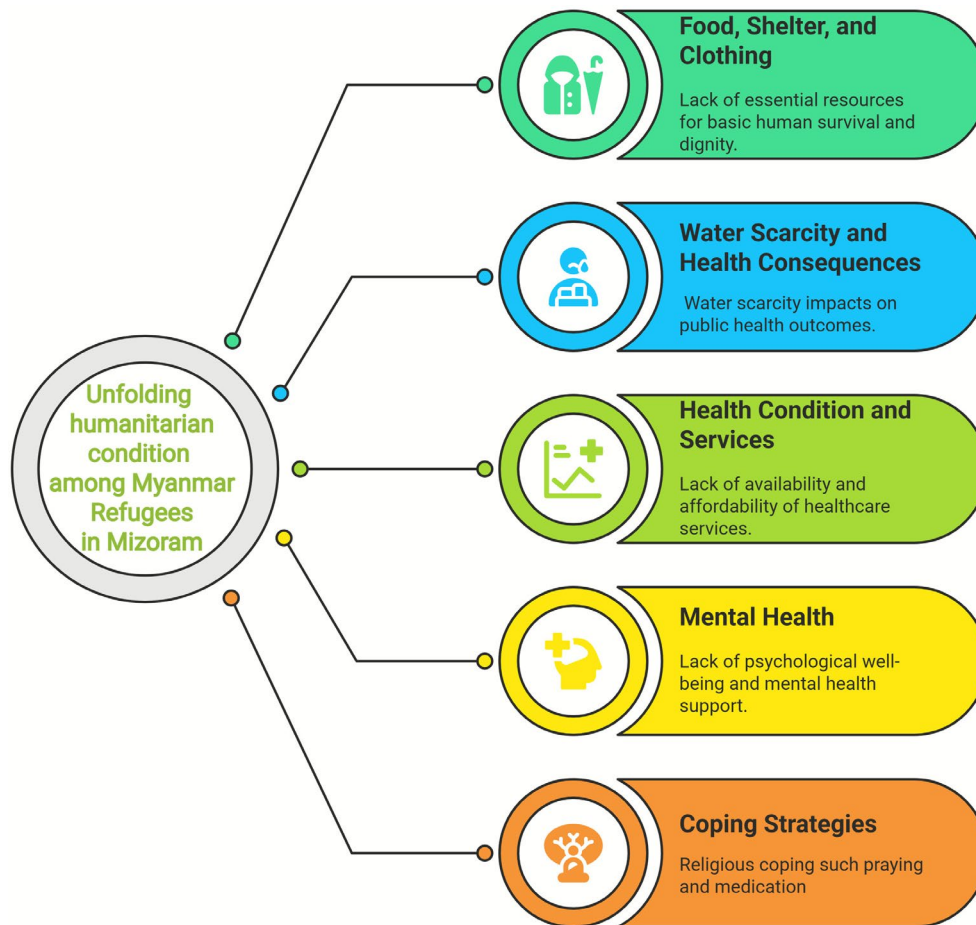


FIGURE 1 | Visual representation of humanitarian crises, healthcare access barriers, and mental health coping strategies among Myanmar refugees in Mizoram, India. *Source:* Author constructed based on thematic themes.

the ground is rare, leading to the refugee community receiving little aid.

To date, we have not received any humanitarian assistance. For instance, we requested a waterproof roof tarp to protect from rain and wind. No NGO has yet responded to our request
(Lawngtlai District, Camp leader, 34 years, Male).

The challenges faced by refugees in the Lawngtlai District are compounded by their existing struggles with isolation, inadequate infrastructure, and limited access to essential services, including food, shelter materials, healthcare, and education, which remain largely unmet.

3.3 | Water Scarcity and Health Consequences

Refugees encounter significant challenges in accessing clean water because of the mountainous terrain of Mizoram. Notably, only the Tuirial Refugee Camp in the Aizawl District reported an exception to this issue, as it benefits from a pipeline water supply and its proximity to Aizawl, the capital of Mizoram State. In contrast, the majority of the refugee population relies

on rivers, such as the Tiau River, and nearby refugee camps for their water supply. This reliance on unhygienic water sources, combined with inadequate waste management and overpopulation, has led to the prevalence of various illnesses in refugees.

A large number of people are dependent on the Tia River for drinking water and daily necessities. However, many refugees live in the area, and there is a lack of systematic trash collection, resulting in heavily populated rivers. This leads to many people suffering from diarrhoea and other skin illnesses due to unhygienic water.
(Zokhawthar District, Mizoram, Camp helper, 31 years, Female).

To address water scarcity, the YMA addressed this issue by constructing a water wall within the refugee camps. This initiative has significantly improved access to clean drinking water and enhanced health outcomes for many refugees. However, the construction of such a water wall presents challenges for numerous refugees owing to the mountainous terrain and limited financial resources available to the YMA.

3.4 | Health Condition and Services Accessibility, Availability, and Affordability

The health vulnerabilities of refugee populations have been exacerbated by the COVID-19 pandemic and overcrowded living conditions prevalent in refugee camps. Only certain refugee camps in the Saiha District and Lawn Tai District have partially received COVID-19 vaccinations (Table 1), while other refugee populations have not received any doses. Leaders of the Saiha and Lawn Tia refugee camps reported that most of their members received only one dose and did not complete more than two doses of vaccinations.

In addition to the challenges posed by the COVID-19 pandemic, refugees are particularly susceptible to illnesses such as diarrhea, seasonal influenza, and asthma. This vulnerability is primarily due to inadequate access to clean drinking water, overcrowding, and poor hygiene. The difficulty in maintaining social distancing in such environments exacerbates the risk of infection. They experienced several illnesses that were unfamiliar to them.

We also suffer from an overpopulation problem, leading to different illnesses in our refugee population, he said. Symptoms may include stomach pain and body aches. The rainy season is particularly conducive to the spread of influenza. At least one member of each household was ill.

(Saiha District, Camp leader, 39-year, Male).

To address the primary healthcare needs of refugees, the Institute of Chin Affairs and Doctors Without Borders has implemented mobile health services in refugee camps. However, these organizations can reach only a limited number of camps because of geographical and financial constraints. Reports indicate that only a few camps receive basic healthcare services from these organizations, whereas others suggest that those organizations primarily distribute health information and provide minimal services.

In addition to the limited healthcare provided by NGOs in refugee camps, the geographical distance from the nearest hospital is a significant barrier to timely medical treatment. In response, several refugee camps established their own health clinics to meet the population's basic needs through voluntary cooperation. For instance, the health clinic at the Tural Camp in the Aizawl District operates on Mondays, Wednesdays, and Saturdays. However, it has been observed that the clinic is limited to providing only basic healthcare services, necessitating that individuals travel to urban areas to access certain treatments at their own expense.

Some refugee camps within the Saiha District have established health clinics in collaboration with healthcare workers involved in Myanmar's civil disobedience movement (CDM) following the military coup. This initiative was necessitated by the fact that the nearest civil hospital is located in Lunglei, a 45-min drive from the camps. However, it is crucial to acknowledge that medical fees and transportation present significant barriers for patients attempting to access Lunglei Hospital.

A CDM public health doctor and nurse are at our refugee camp. Upon arrival, COVID-19 infection peaked. We operate our own clinics as part of our efforts to provide basic healthcare services. Some NGOs provide basic medical support. However, there is a lack of adequate medicine and equipment to address the various needs of patients with various illnesses.

(Saiha District, Camp leader, 36-year Male).

Refugees in the Zokhawthar district did not have a healthcare clinic in their refugee camps, as reported by participants. The nearest healthcare facility was located 5 km away. Refugees find it difficult to obtain medical treatment because of the high cost and difficulty of transportation due to the hilly terrain and lack of available motorcycles. Alternatively, the Institute of Chin Affairs occasionally provides mobile healthcare to refugee camps in the Zokhawthar District, which improves their health but unable to meet the emergency needs.

Although a mobile healthcare service is occasionally available, refugees still need to go to Champhai Hospital to receive emergency medical care because no clinics or healthcare facilities are nearby. Therefore, they need a healthcare center in their refugee camps for timely treatment.

(Zokhawthar District, Camp helper, 31 years, Female).

In the Lawn Tai District, some refugee camps built their own health clinics but lacked medical equipment, including first-aid supplies, in emergencies. The nearest hospital was approximately 6 miles away. Geography and transportation challenges make access to healthcare difficult for pregnant women, older adults, and children under 5 years of age.

Moreover, all refugee camp leaders highlighted that financial hardship among refugees is another challenge in seeking medical treatment. Refugees were not permitted to work as open vendors or raise livestock. They could partially work daily based on mutual understanding with the local employer. Nonetheless, they could only obtain two or three working days per week and earned no more than 1000 Indian rupees.

We face difficulty in seeking medical treatment at the hospital because even registration costs 200 Indian rupees before treatment commences. How will we pay for our medical checkup costs and purchase medicine because we earn a limited income? This is a challenging situation for all of us in the camp.

(Lawn Tai District, Camp leader, 34-year Male).

3.5 | Mental Health

The military coup in February 2021 devastated the aspirations of many refugees and led to the loss of their possessions, including homes, due to indiscriminate airstrikes and widespread destruction. Consequently, many sought refuge in foreign countries to

escape the human rights violations perpetrated by the Myanmar military. Therefore, these individuals experience a range of mental health challenges, including homesickness, insomnia, and depression as they struggle to meet their basic needs within the camps.

The refugee camp leader stated that many of us would be in different situations if there was no military coup. Some may be successful in their businesses or endeavors. We might live happily with our families or loved ones.

(Lawn Tai District, Camp leader, 34-year Male).

However, the Indian central government does not officially recognize them as refugees, resulting in some being detained and repatriated to conflict-affected areas in Myanmar. This lack of legal recognition has further exacerbated the psychological distress and overall mental well-being of refugee communities. Moreover, insufficient access to humanitarian aid to meet basic needs, including food insecurity, shelter, healthcare access, low employment opportunities for income, and inadequate educational opportunities for their children, has worsened their mental health.

Since we do not have basic needs such as rice and oil for daily survival, this affects our mental health, he said. No employment opportunities were provided. Occasionally, jobs such as casual work are available; however, these positions are insecure. There may be a job today, but not tomorrow, and it is impossible to predict when the next job will be available. Sleeping at night is challenging because we are concerned about our children's food, medical care, and educational needs.

(Camp leader, Turial Camp, Aizawl District, 48-year Female).

Decreasing humanitarian assistance from non-governmental organizations, especially in 2023, is another factor affecting the mental health of the refugee population.

The number of humanitarian supports has declined after three months of building the camp since those NGOs and community organizations are also experiencing financial difficulties. For example, even if we receive support, each family receives only one kilogram of rice. Since we have many refugees, they could not donate enough support to cover our needs.

(Saiha District, Camp leader, 39-year Male).

All refugees yearned for the day they would return to their homeland in Myanmar. Unfortunately, the military has torched hundreds of homes, and many refugees are left with nothing. Consequently, many refugees suffer from mental health problems. Some refugees are physically disabled from military landmines and indiscriminate attack. Those who have lost their

homes and are physically disabled often experience severe mental illness.

The state of mental health is particularly severe among refugees whose homes have been burned down by the military and among those who have been disabled as a result of military attacks. Since there is no place for them to return home, and all their properties have been burned to the ground.

(Zokhawthar District, Camp helper, 31 years, Female).

Severe mental health challenges have been noted among older refugees, even when they are in good physical health. They often express feelings of homesickness during meals and social gatherings in refugee camps. Despite the passage of time, their mental condition remains unchanged. Some have developed new friendships within the camps, yet they still long for their homes and relatives.

Older refugees are most likely to suffer from mental health issues. They missed their house, livestock, and farm.

(Saiha District, Camp leader, 36-year Male).

3.6 | Coping Strategies

The findings indicate that the mental health of refugees is influenced by factors such as dire humanitarian aid, lack of access to employment opportunities, and homesickness.

There is no mental healthcare support group, including those from non-governmental organizations. A program called Doctors Without Borders, the Jesuit Refugee Service (JRS), provides mental health support, especially for children. However, these services are unavailable in many refugee camps. There may only be ten refugees out of 100 who receive mental health care.

(Zokhawthar District, Camp helper, 31 years, Female).

Nevertheless, the camp leader noted that mental health support was absent in refugee camps. To cope with their daily challenges and mental health issues, refugees rely on various strategies such as devotion to God, communal worship, and prayer.

We pray to God for the release of our depression and feelings. On Sundays, we gather in a community church in a refugee camp for worship services

(Camp leader, Turial Camp, Aizawl District, 48-year Female).

The majority of refugees are Chin people, and they are predominantly Christian. Even though we face many challenges in our daily lives, we pray to God,

read the Bible, and attend church to cope with our problems

(Lawn Tai District, Camp leader, 34-year male).

An additional coping mechanism involves seeking social support, as individuals often gather within their communities to share tea and engage in conversations about mental health concerns. These communal interactions foster a sense of solidarity and belonging and provide emotional relief and mutual understanding in the face of displacement-related stress.

4 | Discussion

Myanmar refugees in India fled the war-torn conditions in their native land in Myanmar and arrived in India. Most of them were arrived with only the cloth there were wearing as they left all their belongings. In response, the Mizoram State government formed a Village-Level Committee on Myanmar Refugees to provide humanitarian assistance. However, the trend of providing this assistance has been declining since 2023, and they are facing food insecurity and other basic needs issues. Thus, Myanmar refugee populations will continue to face significant hardships, including food insecurity and unmet basic needs, without adequate humanitarian aid or NGO support. This is evidenced by the existing conditions in the African and European regions (Napier et al. 2018; Terragni et al. 2020).

Myanmar refugees are at a heightened risk of contracting infectious diseases, which can be attributed to various factors, such as limited access to sanitation and clean water, overcrowding, and the prevalence of diseases within refugee camps and their surrounding environment. This finding is supported by existing literature from the Middle East and globally (Abrahamsson et al. 2022; Hanieh et al. 2016; Khai 2023; Taha et al. 2023). Moreover, the Myanmar refugee population in India are vulnerable to waterborne diseases and neglected tropical diseases due to the region's mountainous terrain and densely populated river areas, which are impacted by inadequate waste management and overpopulation in the camps.

Furthermore, Myanmar refugees do not have health clinics run by international non-governmental organizations (INGOs) or United Nations Agencies to provide healthcare services. They built their health clinics to meet the population's basic needs through voluntary cooperation but lacked some medical equipment, including first aid supplies, in case of an emergency. For instance, a report has highlighted that 8 people have died and at least 45 have fallen ill due to a waterborne disease outbreak among refugees in camps situated in India's Lawngtlai District (Ukhrul Times 2025). This situation is largely attributed by overcrowding, poor sanitation, and restricted access to clean drinking water and healthcare services, highlighting the cross-border transmission of preventable diseases amid weakened public health systems and insufficient humanitarian responses. Therefore, Myanmar refugees residing in Mizoram State, India, are particularly vulnerable to infectious diseases compared to refugee populations in other parts of the world, where international nongovernmental organizations and United Nations agencies provide more consistent healthcare support. In contrast, the limited presence of humanitarian actors in Mizoram

has left many without adequate medical assistance, further heightening their exposure to preventable illnesses and fatality. For example, Rohingya refugees have access to structured international health interventions (UNHCR 2021a), while Ukrainian refugees and displaced individuals received under temporary protection with a grant of 4 million to improve their healthcare access in several European countries (European Commission 2023). However, for the Myanmar refugee population in Mizoram, the nearest hospital is approximately 5 miles away, and financial hardship is a significant challenge in seeking medical treatment.

The lack of COVID-19 vaccines in most refugee camps, coupled with the prevalence of infectious diseases and the absence of health clinics run by INGOs and United Nations Agencies to provide healthcare services, poses susceptibility to contracting illnesses among the Myanmar refugee population. Notably, more than 150 countries have incorporated COVID-19 vaccination strategies that involve refugees (UNHCR 2021b). However, the mere presence of these policies does not always guarantee equal access to the vaccine, even for one of the largest Rohingya refugees in Cox's Bazaar, Bangladesh (Alam 2023). The participants in this study reported that the COVID-19 vaccination had only been partially administered in the Saiha District and Lawn Tai District refugee camps because of the social and ethnic relationships that the local community had with the refugees, and most refugee camps in other districts had not received any doses to the date of the interview.

Furthermore, the Indian central government failed to recognize the status of Myanmar refugees in India, which deteriorated humanitarian support from humanitarian organizations and the non-intervention of INGOs and UN agencies. Additionally, they were excluded from the Association of Southeast Asian Nations (ASEAN) humanitarian assistance plan despite being distributed to other areas of Myanmar (Radio Free Asia 2022). This situation exacerbates daily challenges due to the lack of humanitarian assistance and necessities, unlike some refugees in other countries who are under the protection of the United Nations High Commissioner for Refugees (UNHCR). Consequently, numerous Myanmar refugee communities are grappling with multiple mental health concerns, such as homesickness, insomnia, and depression, due to waning support from local NGOs and churches, which has been exacerbated by rising food insecurity and unmet basic needs.

In contrast, Myanmar refugee communities do not have access to mental health and psychosocial support, suggesting that crucial interventions are absent (Grasser 2022; Miller and Rasmussen 2017). Consequently, they seek solace in religious practices, such as biblical studies, attending church, and social gatherings to share feelings.

5 | Strengths and Limitations of the Study

This study examines the daily challenges and structural barriers encountered by Myanmar refugees in accessing humanitarian relief in Mizoram, India. Through qualitative inquiry, it explored the institutional and policy-related obstacles that hinder effective aid delivery, while shedding light on the lived realities

of displaced populations in camp settings. Although the findings are not generalizable to all Myanmar refugees across India, owing to sample size limitations and contextual specificities, they offer critical insights into the systemic and logistical difficulties faced by this vulnerable group.

This research acknowledges several constraints, particularly technological and infrastructural limitations within refugee camps, such as unreliable Internet connectivity and restricted mobility, which influenced participant recruitment and data collection. Despite these challenges, this study yields valuable qualitative perspectives on the administrative hurdles faced by camp authorities and the daily struggles of refugees, thus contributing to a deeper understanding of the gaps in humanitarian response mechanisms.

Furthermore, this study underscores the urgent need for expanded research to address the critical yet underexplored dimensions of Myanmar refugees' experiences. Key areas requiring further investigation include food security issues, health vulnerabilities, and mental health conditions to deliver the most effective interventions to support them. By identifying these priority areas, this study advocates for evidence-based interventions tailored to the specific needs of Myanmar's refugee populations. Future research should adopt a mixed-methods approach to quantify disparities while preserving the nuanced narratives captured in this study, ultimately informing more equitable and effective policy responses for the future.

5.1 | Practical Policy Implications

The following policy implications aim to improve the living conditions of Myanmar refugees and asylum seekers in India:

First, the refugee camps for Myanmar refugees in Mizoram State are not officially recognized by the Central Government of India, and their temporary settlement depends on permission from the state government of Mizoram. As a result, United Nations agencies and international NGOs are unable to provide formal humanitarian assistance. Consequently, Myanmar refugees struggle to meet their basic needs, relying solely on the Mizoram state government's limited and under-resourced humanitarian support. Therefore, it is imperative for the Central Government of India to recognize the presence of Myanmar refugees, who are fleeing the war-torn in their homeland and to collaborate with the Mizoram State Government in addressing their needs. This should include granting access to United Nations agencies, international NGOs, and other humanitarian organizations to deliver essential humanitarian aid and support the social and mental well-being of the displaced population. Particularly, this will provide an opportunity for resettlement programs in a third country and durable solutions in the long run, as the political turmoil in Myanmar may take a long time to resolve.

Second, United Nations agencies, international non-governmental organizations, and other humanitarian actors should advocate for the Central Government of India to permit the delivery of humanitarian aid to Myanmar refugees. Nearly 5 years into the crisis, this population continues to face severe difficulties in accessing basic necessities such as shelter, food,

clean water, and healthcare, which are the fundamental rights highlighted in the WHO's Global Action Plan (2019–2023) for promoting the health of refugees and migrants. Moreover, mental health support remains essential, as the WHO underscores that genuine health cannot exist without mental wellbeing.

Third, it is crucial for Myanmar's National Unity Government (NUG) to engage directly with refugee camp leaders to listen to their voices and concerns regarding living conditions. Moreover, the NUG should actively seek potential international donors and collaborate with government officials, United Nations agencies, and NGOs to mobilize assistance for Myanmar refugees in India, who continue to face dire humanitarian circumstances.

Finally, Myanmar refugees in Mizoram State should work systematically with local government authorities, non-governmental organizations, and church institutions to advocate for the official recognition of their refugee status by the Central Government of India and to enable United Nations agencies to provide humanitarian assistance effectively.

6 | Conclusions

The Myanmar refugee population in India encounters significant challenges in fulfilling their basic needs due to the uncertain futures they face, as neither the central government nor the United Nations recognizes their status as refugees. This lack of recognition hinders the distribution of humanitarian aid, the prospect of resettlement in third countries, and the exploration of durable solution options. Consequently, this situation adversely affects mental health, exacerbating post-traumatic stress resulting from the conflict in Myanmar. While assistance from Mizoram State and local NGOs addresses the fundamental needs of Myanmar refugees, humanitarian aid has become increasingly limited since the conflict intensified nearly 5 years now. This situation appears to have worsened following Donald Trump's executive order in 2025 to halt humanitarian aid, including USAID.

Author Contributions

The authors conducted the literature review, study design, data collection, transcription, and analysis.

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Ethics Statement

Ethical approval and consent to participate in the study were obtained from the Research Ethics Committee and Postgraduate Student Committee (PSC) of Lingnan University in Hong Kong. All procedures were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and the Declaration of Helsinki of 1975, as revised in 2000. All participants were informed that their participation was voluntary. Written and oral informed consent was obtained from all participants before conducting the interviews and audio recordings in accordance with research ethics. All participants were assigned pseudonyms. All methods were performed in accordance with relevant guidelines and regulations.

Conflicts of Interest

The author declares no conflicts of interest.

Data Availability Statement

All data generated or analyzed during this study are included in this published article. The datasets generated and/or analyzed during the current study are not publicly available to preserve the anonymity of the study participants.

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