

Fault Lines of Refugee Exclusion: Statelessness, Gender, and COVID-19 in South Asia

ROSHNI CHAKRABORTY AND JACQUELINE BHABHA

Abstract

Despite widespread recognition of the right to a nationality, statelessness and its attendant vulnerabilities continue to characterize the lives of millions in South Asia. During the onset of the COVID-19 pandemic, when states turned inward to protect their own citizens, refugees and de facto stateless persons found themselves excluded from humanitarian services and health care and were denied the ability to claim rights. Stateless women faced the additional burden of gender-based violence, a hostile labor market, and the threat of trafficking. This paper analyzes gender and statelessness as vectors of exclusion in South Asia, where asylum seekers are neither recognized by law nor protected by social institutions. We argue that citizenship constitutes an unearned form of social capital that is claimed and experienced in distinctively gendered ways. The pandemic has shone a bright light on the perils of statelessness, particularly for women, who face exacerbated economic inequities, the forced commodification of their sexuality, and exclusion from mechanisms of justice.

ROSHNI CHAKRABORTY is an undergraduate student in the Committee on Degrees in Social Studies and the Department of Global Health and Health Policy at Harvard College, Cambridge, USA.

JACQUELINE BHABHA is Professor of the Practice of Health and Human Rights at the Harvard T.H. Chan School of Public Health, Director of Research at the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University, and Jeremiah Smith Jr. Lecturer at Harvard Law School, Cambridge, USA.

Please address correspondence to Roshni Chakraborty. Email: roshnichakraborty@college.harvard.edu.

Competing interests: None declared.

Copyright © 2021 Chakraborty and Bhabha. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

Introduction

Far from being “great equalizers,” diseases reflect and reinforce preexisting hierarchies. Structural inequalities in wealth, housing, health care, employment, and social capital place the poor and the socially vulnerable at a higher risk of infection and death. At the same time, the fear and suspicion engendered by epidemics exacerbate the vulnerabilities of those perceived as “other” or “outsiders,” populations whose survival and dignity are already compromised by social exclusion mechanisms such as legal invisibility, geographic ghettoization, and social ostracism. For refugees resettling in South Asia, our area of focus in this paper, these forms of marginalization are an everyday reality. The denial of a viable and effective legal identity precludes the ability to even *claim* rights in states that already fail in their obligations to provide them.¹

Citizenship, in both its legal and social sense, represents, we argue, an unearned form of social power and capital. Where, as is the case in India, Pakistan, and Bangladesh, prevailing international law protecting refugees has not been ratified, forced migrants are left without the secure legal status awarded to recognized refugees, a deficit that magnifies the challenge of accessing state protection and securing social capital within the host community. The status of these forced migrants is thus best captured by the notion of *de facto* statelessness, which signals their lack of access to the protective responsibility of any sovereign nation. *De facto* statelessness in South Asia is a perilous status at the best of times, given the central role of the state as a dispenser of fundamental services and protections. It is a particularly challenging status during a global pandemic such as COVID-19, when hostility toward outsiders is exacerbated, the availability of essential humanitarian services is compromised, and an informal labor market generating subsistence income is brought to a halt.

To the impacts of *de facto* statelessness must be added those of other critical social determinants of health and well-being, including gender, which intersect to multiply the risks of stigmatization and exclusion. The entrenched exploitation and

control of female sexuality, as a commodity to be exchanged or dominated, accelerates during times of distress, as it has during this pandemic. This paper explores the gendered impact of COVID-19 on forced female migrants in South Asia, who already face strong exclusionary pressures because of their status as noncitizens of the broader polity.

Citizenship, statelessness, and gender

Theoretical framework

Citizenship is a status outside the reach of refugees in South Asia. The refusal of India, Pakistan, and Bangladesh to ratify the 1951 Refugee Convention, the primary and widely ratified international legal instrument for refugee protection, or its 1967 Protocol, denies asylum seekers in those three countries the opportunity to qualify for the legal status (and related documentary proof) of refugees. Instead, they are relegated to the precarious and degraded status of “illegal immigrants.” This protection deficit deprives these forced migrants of critical rights enshrined in these conventions, including protection from *refoulement* (return to a place where they fear persecution) and the rights to work, study, and receive public assistance.² Moreover, because these migrants lack access to a protective state, they are *de facto* stateless, even though they may have a *de jure* (legal) nationality.³ Both *de facto* and *de jure* stateless people are unable to access the privileges, services, protections, and rights that citizens can demand from their states. The denial of refugee status (with the future prospect of a path to permanent residence and thence citizenship) erects an impenetrable barrier between undisputed members of the collective and such “outsiders.”

This barrier extends beyond status and documentation. In his classic work on the topic, T. H. Marshall describes citizenship as a multilayered “status bestowed on those who are full members of a community.”⁴ Christian Joppke expands on this conception by exploring the complex interplay between status, rights, and identity embedded in our notions of citizenship today.⁵ The status affords formal and legal membership in a state; the rights generate the

ability to assert legitimate claims to the protection and services of the state; and the identity imparts a sense of social membership within a collective. Pregnancy and motherhood, for example, generate distinctive claims on state protective services, as does gender-based violence. Citizenship deficits affect women and men differently. Citizenship is also experienced and claimed in gendered ways. Because women are essential to the reproduction of the nation, and therefore represent it biologically and culturally, their bodies are prime targets for domination and destruction in times of crisis.⁶ The history of sexual violence in the context of conflict illustrates this point vividly: women's bodies are often the terrain on which enemies are subjugated and the superiority of nations claimed through the assertion of brute masculinity. The experience of Rohingya refugees from Myanmar, of whom over a million are now living as (legally) stateless persons in Bangladesh, is a powerful case in point. Thousands of Rohingya women were brutally raped by Myanmar security forces in "clearance operations" in 2016–2017.⁷ A report by Human Rights Watch and Fortify Rights argues that humiliation and cruelty were key elements of this systematic campaign of sexual violence. Not only were women assaulted, but their genitals were mutilated, their breasts were slashed off, and their children were murdered in front of them. Of the rape cases found by a Human Rights Council mission, 80% were gang rapes.⁸ However, it would take more than migration to Bangladesh to escape the violence. Between August 2017 and March 2018, a total of 6,097 incidents of gender-based violence were reported in the refugee camps in Cox's Bazar, which remain a hotbed of violence against women.⁹

To this traumatic history is added, now, the impact of restrictions and isolation generated by official responses to the COVID-19 pandemic. Women and girls in communities of forced migrants are—even more than their non-displaced female peers—at risk of violence and abuse in communities where hardships, lack of services, and the absence of mobility and distraction compound preexisting stressors. We explore these themes in more detail in what follows.

Refugees in South Asia

The plight of refugees in South Asia is determined by complex systems of registration and highly politicized asylum processes, generating different levels of access to state protections.

Bangladesh is home to over 1.2 million stateless Rohingya refugees from Myanmar who, legally, fall under the Foreigners Act of 1946, which classifies those who have entered without proper travel documents as "illegal migrants." In 2015, Bangladesh and the United Nations High Commissioner for Refugees (UNHCR) began registering these Rohingya asylum seekers as "forcibly displaced Myanmar nationals"—not a robust legal status (and certainly a far cry from registered Convention refugee status) but preferable in terms of access to critical services and legal documentation to the "illegal" status that the 250,000+ unregistered Rohingya occupy.¹⁰ Unregistered Rohingya live in informal camps and face much greater difficulty accessing the rather minimal health care and education that their registered peers have access to.¹¹ One study found that unregistered children were 10 times more likely to be working than those registered and living in formal camps, and that 86% of unregistered refugees—double that of registered refugees—reported food shortages.¹² The difference in status (and, consequently, socioeconomic conditions) between registered and unregistered Rohingya, both of whom remain stateless, demonstrates the importance of access to a legally recognized registration process.

India hosts over 200,000 refugees, a majority (60%) of whom are Rohingya, followed by Afghans and Sri Lankans. These refugees, too, are classified as "illegal migrants" under the Indian Foreigners Act of 1946, which gives expansive powers to the state to expel or detain those who enter without valid travel documents, directly repudiating the core Refugee Convention principle of non-refoulement. Because of the absence of a binding international legal framework, geopolitical considerations rather than humanitarian norms dictate how refugees in India are treated. For example, Tibetans fleeing the 1959 Tibetan uprising were granted asylum and given all the rights of refugees, while Sri Lankan Tamils

fleeing that country's brutal and prolonged civil war were placed and remain in heavily monitored camps.¹³ The denial of refugee status and the refusal of the Home Ministry to accept papers issued by UNHCR has blocked refugees' access to schools and universities, formal employment, housing, official sources of borrowing, and state services.

Pakistan has received over 2.4 million Afghan refugees, of whom 1.4 million are registered by UNHCR and 1 million remain unregistered. Registered Afghan refugees are entitled to a renewable Afghan Proof of Registration card that affords them temporary legal status within Pakistan. As is often the case for vulnerable minorities, the enabling aspects of the registration system exist in tension with a darker state goal. Sanaa Alimia argues that these "ID cards for Afghan refugees are a tool of surveillance that facilitates ... social and physical exclusion."¹⁴ Once the Proof of Registration card expires, the benefits associated with it—namely, the right to a temporary legal stay in Pakistan and protection against refoulement—do too, but the surveillance capabilities it affords do not. The process of applying for an extension is random and opaque, making the cardholder "illegal" for long periods during which he or she is at risk of violence and extortion by state officials.¹⁵ In 2016 and 2017, Pakistan forcibly repatriated 365,000 of the country's registered refugees and 200,000 of the unregistered refugees, in what Human Rights Watch called "the world's largest unlawful mass forced return of refugees in recent times."¹⁶ For refugees in Pakistan, COVID-19 is a legal existential threat—their very presence in Pakistan hangs in the balance, and many have expressed fear of being forcibly returned to Afghanistan despite the continuing violence because of the severe difficulties they face in renewing their registration cards. In August 2020, these "voluntary" repatriations were restarted.

Refugees, migrants, and minorities as the "other"

Throughout history, epidemics and disease have brought with them the intensification of prejudice.

Recent scholarship has focused on how epidemics are not just health-related phenomena but social and intellectual *constructs* that "[illuminate] wider relationships between social groups and between state and society."¹⁷ As fears about contamination and infection spread, those who are marginalized easily become the prime suspects in the witch-hunt to find the vectors. In tracing the social history of epidemics, Paul Slack finds exactly this need to isolate and accuse:

*Carriers of disease were identified and scapegoats stigmatised: foreigners most often ... since epidemic disease came from outside, but also inferiors, carriers of pollution of several kinds, among whom disease had its local roots.*¹⁸

In South Asia, the perception of the refugee and migrant as dirty and contaminated draws on a long history. During the plague in the early 20th century, those who fled from infected towns such as Bombay (present-day Mumbai) were blamed for spreading what was essentially an urban disease to the rest of the country. It was untouchables, migrants, and other groups considered deviant who were most likely to be reported to authorities because of suspected sickness.¹⁹ Studies of HIV/AIDS-related stigma have documented animosity not only toward sex workers but also toward truck drivers, migrant laborers, illegal migrants, and others whose mobility was blamed on them because they were allegedly "not satisfied with what they had at home."²⁰

A narrative about the "foreigner" spreading disease has dominated South Asian popular discourse during the COVID-19 pandemic. In 2020, several reports claimed that Rohingya refugees were deliberately infected and sent to different parts of India as agents of an Islamic conspiracy to spread COVID-19. The Home Ministry wrote a directive to all states in India directing them to track and screen Rohingya refugees because some were suspected of attending the congregations blamed for spreading the virus, although no proof of this has been found.²¹

Rohingya refugees in Bangladesh have faced similar scapegoating in the last few months,

shunned as “unclean” and vilified for allegedly spreading the disease. Chowdhury Rafiqul Abrar, a professor at Dhaka University, has noted the irrationality of this “virus spreader” allegation, given the two-month gap between Bangladesh’s first case (on March 8, 2020) and the first case in Rohingya camps (on May 14, 2020).²² In Bangladesh, newspapers have carried headlines about COVID-19 cases in Rohingya refugee camps, accompanied by assertions that “locals [are] in panic.”²³ These responses to COVID-19 are part of a long history where states shirk public health responsibility and direct fears and blame in an outward direction.

COVID-19: The South Asian context

Though the virus has transcended borders and affected people of all nationalities, ethnicities, and genders, some populations, such as African-Americans in the US, caregivers, and nursing home residents, have been far more affected than others.²⁴ Globally, the risk of contracting the novel coronavirus is similar for men and women, though mortality rates have been higher for men in most contexts.²⁵ Scientists have explored the reasons for these disparities by examining differences in the immune system, hormones, preexisting health conditions, and social determinants of health, such as help-seeking patterns, nature of employment, cultural practices, and, access to testing.²⁶

Given the low levels of testing, it is tough to determine the direct health impacts of COVID-19 on refugee populations. In Bangladesh, as of September 27, 2020, there had been 4,721 confirmed cases in Cox’s Bazar, and as of the end of October 2020, 336 cases across the 34 refugee camps.²⁷ One study projected that the introduction of a single case into the Cox’s Bazar camps would lead to at least 1,000 people infected, even in the best-case scenario, prompting activists and aid workers to warn that low reported infection numbers reflect low testing, not a low incidence of COVID-19.²⁸ Another found that 25% of refugees reported at least one symptom of COVID-19.²⁹ Of the confirmed cases within the camps, 73% were male and 27% were female. Of the nine deaths, however, six were female and

three were male. This likely indicates that women are being tested at far lower proportions and only in critical cases. The desire to avoid health care providers is evidenced by the fact that 42% of those who sought treatment for COVID-19 had first tried to treat themselves at local pharmacies.³⁰ Moreover, health-seeking behaviors and decision-making reflect gendered dynamics: 61% of women reported needing the permission of a male member of the household to access health services when they exhibited symptoms of COVID-19.³¹ Medical facilities are not sufficient, either, with only 1 intensive care unit, 34 isolation beds, and 2 ventilators serving all the people in Cox’s Bazar.³² Afghan refugees in Pakistan have seen a similar trend, with only 18 refugees testing positive but 5 of them dying.³³ The high fatality rate indicates a hesitance to seek medical services and testing except in the most critical of cases. In India, the limited mandate of the UNHCR and the limits on nongovernmental organization (NGO) staff who are not listed as “essential services” prohibit them from administering expansive health services for refugees or collecting data about the prevalence of COVID-19.

Refugees may also have co-morbidities that place them at higher risk of COVID-19. Infectious diseases disproportionately affect crowded refugee camps, with the camps in Cox’s Bazar only recently recovering from cholera and diphtheria outbreaks. Refugees have much higher rates of malnutrition and anemia, which reduce the ability of the immune system to fight diseases. In one study of Rohingya children in Bangladesh, 43% had chronic malnutrition, 24% had global acute malnutrition, and 48% had anemia.³⁴ Both anemia and malnutrition have been found to be associated with an enhanced risk of severe COVID-19 infections, showing the direct health impacts of their socioeconomic conditions.³⁵

Epidemiological statistics have to be evaluated in tandem with data on the gendered dimensions of the pandemic. The virus may not actively target women, but its impacts magnify preexisting inequities and expose fault lines that existed before the pandemic. Women in South Asia are more likely to be engaged in informal work with no job or wage security, a situation that has forced them to

accept lower wages and longer working hours.³⁶ As hunger and unemployment increase, malnutrition is set to become a major concern for girls, whose access to food is already lower than that of boys. The halting of girls' education and an increase in child marriage are two additional concerns, because impoverishment typically entails prioritizing resources for males and commodifying females to preserve family resources. As the mother of a 13-year-old girl explained to the Indian nonprofit organization Aangan, "We have no income in this lockdown but we still have expenses. Since Jyothi is young we will have to pay less money to the groom's family if we fix her marriage now."³⁷

These effects are felt even more intensely by refugees, the majority of whom in South Asia are de facto stateless, legally invisible, and severely disadvantaged in their capacity to claim their rights. Refugee women have been exposed to increased sexual violence in the camps alongside the reduction of crucial NGO services.³⁸ Isolation and stress have exacerbated domestic violence and child maltreatment.³⁹ Historically, the trafficking of women and children is known to have increased during times of crisis and heightened poverty, and is likely to do so during this pandemic, too, given the protection deficit that refugees face. Below, we argue that the combination of de facto statelessness, the deprivation of access to the protective resources of the state, and the impact of long-standing exploitative control of female sexuality generate profound and underestimated elements of pandemic-related threat to refugees in South Asia.

Gendered human rights violations among South Asia's refugees during COVID-19

COVID-19 has intensified the gendered vulnerabilities of displaced and marginalized women, as the fears and restrictions related to the pandemic response exacerbate social, political, and intra-household inequities. With the risks that come from legal invisibility and gendered subordination both within and outside their families and refugee communities, stateless women in South Asia are experiencing the fallout from COVID-19

in a distinctively stressful way.

Economic distress

As elsewhere, in the refugee settlements in South Asia, the risks of contracting COVID-19 have much to do with employment and economic status, and their knock-on effects on residential conditions. Refugees are compelled to work in the informal sector because their legal status prohibits employment. For women, the daily wage labor that they are typically employed in, whether agricultural or sweatshop or construction based, affords no opportunity to maintain social distance or accumulate savings. Informal workers—the vast majority of the working poor in South Asia—cannot afford to stay away from work for long and are much more likely than their more affluent and educated counterparts to be engaged in work that cannot be done remotely.⁴⁰ With social protection safety nets nonexistent for large numbers (as explained below), not working means destitution, with the nutritional and other health risks associated with it. In India, those Rohingya women who work are exposed to hazardous conditions. In Delhi, for example, particularly in the Kalindi Kunj camp, hundreds of women work as waste pickers sorting potentially hazardous medical waste, dangerous under any circumstance but far more so during a pandemic.⁴¹

In Bangladesh, too, stateless Rohingya, denied the legal right to work within the society, nevertheless face a compulsion to work determined by the modalities of aid distribution. Only refugees who are registered with the UNHCR are eligible to receive aid (including food, health services, and education) and to live in official camps. Unregistered Rohingya live in informal camps and face much greater difficulties in accessing health care and education.⁴² Not only are they forced to work to purchase food and health care because they are neither eligible for public assistance nor for aid, but they also have little option but to accept submarket wages, as their illegality dampens their bargaining power. Some stateless families feel compelled to rely on the labor of their children. Children outside the registered camps are 10 times more likely to be working than those in formal camps, with over

20% of unregistered families reporting that their children have to work instead of being in school.⁴³

Economic distress causes other forms of gendered discrimination. For example, activists have been warning about an increasing gender gap in education. Prior to the pandemic, only 18% of Afghan refugee girls were enrolled in schools—half the enrollment rate of boys (39%) and less than half the attendance rate for girls in Afghanistan in the same year—with families saying that they would prioritize the education of their boys over their girls.⁴⁴ This pattern of discrimination is not limited to education. In Afghanistan, where women and girls are much more likely to suffer from malnourishment and nutrition deficiencies, studies have found that male members of the household receive bigger portions and that families feed their sons better than daughters when resources are limited.⁴⁵ COVID-19 makes resources even more scarce, and it is likely that girls' education, nutrition, and well-being more generally will be sacrificed to ensure priority for male family members.

Limited access to health care

Statelessness not only exacerbates the risk of infection; it further limits already constrained options for access to medical care, including maternal and child health. With pre-pandemic rates of stillbirth reportedly as high as one in every five deliveries in some Indian refugee camps—10 times the national stillbirth ratio of 22 per 1,000 births—the prognosis is deeply concerning.⁴⁶ High rates of malnutrition, severely inadequate maternal and child health services, and transport restrictions are likely to negatively affect a whole generation of Rohingya women and children in India and Bangladesh. Maternal health care is also seriously deficient for Afghan refugee women in Pakistan who are not entitled to any form of subsidized medication.⁴⁷ Even before the pandemic, Pakistan had one of the highest maternal mortality rates in the world. A 2009 study found that 41% of deaths among women of reproductive age are due to maternity-related causes, 92% of which are preventable. Only 18% of deliveries are attended by medical personnel.⁴⁸ Now, with no particular attention to the acute needs of

some constituencies, maternity wards have been closed in Islamabad and Khyber Pakhtunwa, where the refugee population is concentrated.⁴⁹

In Bangladesh, the enforced ghettoization to which the Rohingya community has been subjected is cited by Rohingya women as one of the major barriers to seeking maternal health care, and a central reason for high levels of home delivery in unsafe and unhygienic conditions. The United Nations Population Fund estimates that only 22% of deliveries in Rohingya families occur in health facilities. Unregistered refugees face even greater challenges. Even before COVID-19 amplified their vulnerability, unregistered families faced higher rates of child labor, far lower numbers of supervised deliveries, and ubiquitous food shortages.⁵⁰ Before the pandemic, 86% reported food shortages, double that of registered Rohingya, raising concerns about malnutrition, which increases the risk of COVID-19 infections and death. Unregistered mothers are unable to obtain birth certificates for their children or to register them. Without appropriate state intervention to ensure birth registration and access to birthright citizenship if needed, the deficits of statelessness can, like a genetic disability, be transmitted from one generation to the next. The effects of these status differentials due to registration have become increasingly apparent, and unregistered Rohingya women and children will bear a greater burden of the fallout from COVID-19.

In Pakistan, pandemic-related lockdowns have operated as de facto regimes of incarceration, reminiscent of Giorgio Agamben's states of exception in which law is indefinitely suspended.⁵¹ Afghan refugee villages in Lower Dir and Nowshera exemplify this oppressive dynamic. In the early months of the lockdown, they were completely shut down so that the forcibly contained refugee population was placed in quarantine, with the army guarding all entry and exit routes. Medical stores, bazaars, and food stores were closed.⁵² The age-old trope of exiling the "other," identified as contaminator par excellence, has been reenacted with a vengeance. The enclosure of refugees in areas that no longer have regular access to food and medicine demonstrates the extent to which refugees have been

stigmatized.

Sexual and gender-based violence

The lockdowns imposed to halt the spread of COVID-19 have also taken a heavy and violent toll on the mental health of affected constituencies. Isolation accelerates stressors across a range of vectors, and research has shown that contextual stressors that create disadvantages for men within the family, such as losing breadwinner status, can “[influence] individual behavior by reinforcing traditional symbolic structures of male dominance and thus [motivate] violent behavior among men.”⁵³ Reports documenting this familiar dynamic of violence as a male coping mechanism are proliferating. In Cox’s Bazar, where over 1.2 million Rohingya refugees from Myanmar are accommodated in overcrowded and highly unsanitary camps, the lockdown has been accompanied by an increase in gender-based violence. Hundreds of incidents were reported each week during the early weeks of the pandemic in March and April 2020.⁵⁴ Spousal abuse, in particular, has risen steeply, accounting for 76% of total reported cases of gender-based violence in Cox’s Bazar.⁵⁵ In a Bangladesh situation report published in August 2020, UNHCR reported a backlog of 5,000 child protection cases, most of which were registered after the pandemic response. It found that refugee children were exposed to heightened levels of abuse and neglect and were being pressured to work because of dire financial circumstances.⁵⁶ For stateless women and children, however, reporting crime carries the risk of being charged with illegal entry under the Foreigners Act. Thus, Rohingya women are trapped in a situation where their perpetrators have de facto immunity while they are de facto rightless.⁵⁷ The exclusion of stateless Rohingya women and children from public protections and laws available to the majority population in Bangladesh places them at greater harm.

Violence is a product of stressors, triggers, and spatial conditions that allow the abuse to occur. The pandemic lockdown has forced abusers and victims into isolation together in small living spaces, allowing abuse to go unchecked and unseen. The 2019 Joint Response Plan by UNHCR cites congestion

as the central challenge in Cox’s Bazar, finding that refugees living in close proximity are at heightened risk of communicable diseases, fires, and domestic and sexual violence.⁵⁸ In some camps, the surface area is as little as 0.63 square meters per person, while in Kutupalong it is 10.7 square meters, far below the Sphere recommended shelter standard of 30 square meters.⁵⁹ Sexual violence outside the household is also aggravated by flaws in refugee camps’ design, with women voicing complaints about a lack of adequate lighting and toilet-door locks that have long rendered camp sanitary facilities sites of gender-based violence. Women interviewed by the International Organization for Migration said that they used to access water and hygiene facilities at strategic times, such as when men were at work, but that this has become impossible during the pandemic because of the increased presence of men at all hours of the day.⁶⁰ The greater presence of men who are no longer going to work has generated a heightened fear of sexual violence outside the home.⁶¹

Reduced ability to seek help

Ironically, even tragically, the public health response to COVID-19 has simultaneously increased the risk of gendered harms and decreased the ability to seek help. Depriving Rohingya refugees of their ability to provide for themselves forces them into prolonged dependency on aid organizations, a particularly serious survival issue during crises such as that provoked by the COVID-19 pandemic, when most NGOs have had to decrease their presence and suspend their work to comply with public health guidelines. Indian NGOs were not designated “essential services” by the government, and they faced prohibitions on their movement during the first few months of the lockdown. Although Prime Minister Modi had called on these organizations to provide help to the most underprivileged, that message was often at odds with local law enforcement officials who did not let them operate. NGO staff were regularly stopped and in some cases even beaten by police for violating the lockdown regulations.⁶² The UNHCR has distributed food packets to refugees in New Delhi, but other efforts across the country have

been sparse and sporadic, forcing refugees to take on debts and draw on their savings. Importantly, the UNHCR has not been awarded formal status in India and is allowed to provide assistance only to asylum seekers from non-contiguous countries who currently live in urban areas (mostly restricted to urban Delhi). A similar situation arises in Bangladesh, where the UNHCR has suspended the work of 80% of its staff. By the agency's own admission, "the closure of learning centers, child friendly centers and other venues for children has resulted in further exposure of children to protection risks, giving rise to increased behavioral challenges and the adoption of negative coping mechanisms."⁶³ About 88% of the Rohingya population have been highly or totally dependent on aid organizations for life-saving assistance.⁶⁴ But since the arrival of the pandemic, UNHCR has had to reduce its presence by about 80%, and only "emergency food and medical supplies" are being supplied to those whose lives are in immediate danger.⁶⁵

Another challenge in Cox's Bazar is the internet ban imposed by the Bangladeshi government, which was lifted only in August 2020, after heavy criticism from the international community.⁶⁶ Since September 2019, the government had banned the sale of mobile phone SIM cards to refugees, confiscated over 12,000 SIM cards, and ordered telecom companies to severely restrict internet and phone connections in the camps.⁶⁷ These widely criticized regulations had dire consequences during the pandemic. They slowed down the COVID-19 response because information could not be disseminated online, and they prevented refugees from sending or receiving remittances at a time when work was scarce. They obstructed already restricted opportunities for women to seek assistance, as evidenced by the fact that the International Rescue Committee recorded a 50% decrease in gender-based violence reporting by women in February–March 2020, despite evidence that incidents of violence were increasing.⁶⁸ Other hotline and phone communications started by anti-gender-based violence advocates also reported low traffic because of the government's communication ban, demonstrating, once again, how gendered differences generate

differential impacts on access to state services and protections.⁶⁹

COVID-19-induced trafficking: The predictable consequence of a protection deficit

As we have shown, refugee women are exposed to heightened exclusion as a result of their statelessness and to aggravated risks of violence because of draconian lockdown policies. Now that lockdowns are being lifted, however, this community is also disproportionately affected by poverty as employment opportunities and social protections shrink.

One consequence of this process is likely to be a significant increase in the trafficking of female refugees. Natural disasters, conflicts, and economic shocks are known to precipitate trafficking. The 2004 Indian Ocean tsunami and the 2015 earthquake in Nepal triggered a dramatic increase in the trafficking of young people, especially girls.⁷⁰ The same phenomenon occurred during the 2008 recession because large numbers of women were willing to take risks when they had no alternative sources of livelihoods.⁷¹ At the time of this writing, little confirmed empirical evidence of this trend exists. However, the factors known to be associated with the flourishing of trafficking networks are evident. By highlighting them, we seek to draw attention to the significant risks that ongoing policies and concomitant failures to dramatically scale up social protection investments will enable.

COVID-19 is worsening both the supply-side and demand-side factors for trafficking. On the demand side, the economic losses caused by the lockdown accelerate the pressures on employers—such as farmers, builders, and sweatshop owners—to seek out cost-cutting production strategies: highly exploitable labor, such as that generated by trafficking networks, fits that bill. On the supply side, the risk of destitution places immense pressure on families to make choices that avert complete calamity. Where loans are taken, they need to be serviced; where illnesses occur, payments for drugs are needed; everyday consumption requires a source of ready income in the absence

of accumulated savings. All these factors weigh heavily on refugee populations. And in some contexts, cultural norms favor the exchange of female labor—for domestic work, for agriculture, and for sex work—over its male equivalent.⁷²

Statelessness can increase but also *compel* engagement in exploitative labor. In India, the refusal of the Home Ministry to accept papers issued by UNHCR has prevented refugees from receiving the police certification needed to rent or buy accommodation and has forced them to live in slums or at the mercy of local landlords who often demand rent through services.⁷³ Before the advent of the pandemic, the poorest Rohingya refugees had bound themselves to *kabadi* (scrap-dealing) mafias engaged in trafficking refugees from Bangladesh and in usurious moneylending practices.⁷⁴ Afghan refugees in India have also been harassed by landlords during the pandemic and coerced to pay rent despite the order of the central government that tenants must be given at least one month's relaxation from rent. Dependence on informal moneylending networks is likely to increase as humanitarian assistance dwindles and informal employment opportunities grind to a halt. Bonded labor systems have historically targeted refugees and migrants who are ill informed about and unfamiliar with the region. In India, refugee women and children in particular have been targeted because they are viewed as less able than citizen laborers to assert their rights and organize against bondage and exploitation.⁷⁵ Anticipating the likely surge in the use of trafficking as a refugee survival mechanism in the face of COVID-19, several civil society organizations have pressed their respective governments to make available to refugees the national cash and ration schemes introduced following the lockdowns. However, the central government of India has refused to accede to these requests, and the Delhi High Court has rejected petitions to provide emergency services to refugees.⁷⁶

In Pakistan, too, dramatic decreases in income and increases in employment and economic pressures will affect refugee women differentially. Many refugee families are at risk of eviction due to the inability to pay rent, and hunger is increasing,

putting vulnerable women at risk of sexual exploitation and transactional sex. At least half the Afghan refugees in Pakistan live “hand to mouth,” working as daily wage earners, but since the advent of the pandemic, their livelihoods have been destroyed.⁷⁷

The situation in Bangladesh is equally grave. Unemployment, the halting of education, and the reduced provision of food, water, and other services in refugee camps will have devastating effects on Rohingya families.⁷⁸ The Bangladeshi government has consistently blocked refugee self-sufficiency, preventing Rohingya refugees—including many with marketable skills—from accessing the domestic labor market. In one study, 93.5% of Rohingya households reported a decrease in income between 2017 and 2018, with 80% reporting no current income.⁷⁹ The pandemic restrictions are further impoverishing Rohingya families, forcing them into debt. During the pandemic, over a third of Rohingya households have borrowed money for food, health care, and shelter. Those refugees—2% of women and 27% of men—who were earlier working (albeit irregularly) outside the camp or through cash-for-work programs have either lost their employment or have been temporarily furloughed.⁸⁰

Statelessness can aggravate an already challenging situation by providing a spurious justification for punishment instead of protection for trafficked persons who have been rescued. The Indian police have on multiple occasions detained and deported refugees found to have been trafficked. In a much-publicized case in 2019, police in the state of Mizoram detained 12 Rohingya refugees—8 women and 4 boys—before returning them to Assam, the state they had been trafficked from.⁸¹ Because stateless women have no access to justice mechanisms where complaints about trafficking can be raised, the expected post-pandemic increase in trafficking is especially concerning.

Conclusion

South Asia's rejection of basic nondiscrimination and protection principles for refugees, as set out in the 1951 Refugee Convention and other cardinal human rights treaties, creates conditions of

profound rightlessness. The state—through its monopoly over the power to classify subjects into “legitimate” and “illegitimate”—enacts violence through exclusion. This sets the backdrop for the de facto statelessness faced by the refugee women described above. We argue here that statelessness, whether de jure (as in the case of Rohingya) or de facto (as in the case of other forced migrants deprived of refugee status), and gender are two neglected fault lines of exclusion that generate grave harms in the aftermath of COVID-19. A first step toward providing and guaranteeing fundamental human rights to those who are seeking asylum is the ratification of the 1951 Refugee Convention and its 1967 Protocol, which would give these individuals the ability to make legitimate claims on the state and would place states under greater scrutiny if they fail to uphold the enshrined principles. Another important step would be allowing the expansion of nonprofit and humanitarian organizations on which such stateless individuals might rely for basic necessities. Guaranteeing these organizations “essential worker” status during crises, for example, would protect those who are reliant on them from resorting to negative coping mechanisms such as child labor or trafficking. On a more systemic level, however, investments need to be made in the provision of nondiscriminatory education, access to safe housing, and avenues for work that do not compel dependence on aid organizations in the first place.

Legal and political inclusion is, as argued above, only part of the picture but still a crucial step toward generating social membership in the collective. Illegality can spur social exclusion, as evidenced by exploitation at the hands of informal employers and landlords, just as political messaging and prioritization can give a green light to popular discourse that marginalizes refugees on the basis of their “illegality” and religion. Returning to the Joppke citizenship framework discussed at the outset of this paper, the ostracism of refugees as “contaminators” amounts to a denial of social membership and of a sense of legal identity that compounds the precarity associated with the de facto statelessness of South Asian refugees. The intersectional vulnerabilities produced by statelessness and gender

expose refugee women not only to the challenges facing all poor and marginalized communities affected by the pandemic but to additional challenges such as decreased mobility, lack of legal and social recourse in cases of abuse, the threat of trafficking, and exacerbated xenophobia. The grave yet avoidable harms produced for women by the social and legal exclusion described above raise an immediate agenda for intervention, for state and nonstate actors alike. Without dedicated attention to the prevention of future gender-based violence, exploitation, and irreversible health detriments facing South Asia’s refugees in a post-COVID-19 world, the pandemic’s impacts will endure for decades to come.

References

1. J. Bhabha, “From citizen to migrant: The scope of child statelessness in the twenty-first century,” in J. Bhabha (ed), *Children without a state: A global human rights challenge* (Cambridge, MA: MIT Press, 2011), p. 1.
2. J. Hathaway, *The rights to refugees under international law* (Cambridge: Cambridge University Press, 2005).
3. Bhabha (see note 1).
4. T. H. Marshall, *Citizenship and social class* (Cambridge: Cambridge University Press, 1950), p. 28.
5. C. Joppke, “Transformation of citizenship: Status, rights, identity,” *Citizenship Studies* 11/1 (2007), pp. 37–48.
6. N. Yuval-Davis, *Gender and nation* (London: Sage Publications, 1997).
7. Human Rights Watch and Fortify Rights, *Submission to CEDAW regarding Myanmar’s exceptional report on the situation of women and girls from northern Rakhine State* (May 24, 2018). Available at https://www.hrw.org/sites/default/files/supporting_resources/201805myanmar_cedaw_submission.pdf.
8. M. Nichols, “Myanmar troops’ sexual violence against Rohingya shows ‘genocidal intent’: U.N. report,” *Reuters* (August 23, 2019). Available at <https://in.reuters.com/article/myanmar-rohingya-un-idINKCNiVCiTN>.
9. Inter Sector Coordination Group, *Situation report: Rohingya refugee crisis* (March 25, 2018). Available at https://reliefweb.int/sites/reliefweb.int/files/resources/180325_iscg_sitrep.final_.pdf.
10. Human Rights Watch, *“Bangladesh is not my country”: The plight of Rohingya refugees from Myanmar* (New York: Human Rights Watch, 2018).
11. ACAPS, *Rohingya influx since 1978* (December 2017). Available at https://reliefweb.int/sites/reliefweb.int/files/resources/20171211_acaps_rohingya_historical_review_o.pdf.

12. S. Balsari, A. Fuller, M. Chernoff, et al., "The Rohingya in Bangladesh: 2015–2016," FXB Center for Health and Human Rights, Harvard University (April 14, 2019).
13. V. Arulappan, "With poor conditions in camps, Sri Lankan Tamils remain citizens of no-man's land," *New Indian Express* (December 22, 2019). Available at <https://www.newindianexpress.com/states/tamil-nadu/2019/dec/22/with-poor-conditions-in-camps-sri-lankan-tamils-remain-citizens-of-no-mans-land-2079412.html>.
14. S. Alimia, "Performing the Afghanistan–Pakistan Border through refugee ID cards," *Geopolitics* 24/2 (2019), p. 392.
15. *Ibid.*, p. 415.
16. Human Rights Watch, *Pakistan coercion, UN complicity: The mass forced return of Afghan refugees* (February 13, 2017). Available at <https://www.hrw.org/report/2017/02/13/pakistan-coercion-un-complicity/mass-forced-return-afghan-refugees>.
17. R. Chandavarkar, "Plague panic and epidemic politics in India, 1896–1914," in T. Ranger and P. Slack (eds), *Epidemics and ideas: Essays on the historical perception of pestilence* (Cambridge: Cambridge University Press, 1992), p. 205.
18. T. Ranger and Paul Slack (eds), *Epidemics and ideas: Essays on the historical perception of pestilence* (Cambridge: Cambridge University Press, 1992), p. 4.
19. Chandavarkar (see note 17), p. 235.
20. E. S. Lieberman, *Boundaries of contagion: How ethnic politics have shaped government responses to AIDS* (Princeton, NJ: Princeton University Press, 2009), p. 211.
21. R. Mitra and A. Srinivasan, "In India's Rohingya refugee camps, fears of Covid-19 spread and religious scapegoating," *Scroll* (April 28, 2020). Available at <https://scroll.in/article/960356/in-indias-rohingya-refugee-camps-fears-of-covid-19-spread-and-religious-scapegoating>.
22. A. Z. M. Anas, "Rohingya scapegoated as Bangladesh battles COVID-19," *Nikkei Asian Review* (July 7, 2020). Available at <https://asia.nikkei.com/Spotlight/Asia-Insight/Rohingya-scapegoated-as-Bangladesh-battles-COVID-19>.
23. *Ibid.*
24. Centers for Disease Control, *COVID-19 hospitalization and death by race/ethnicity* (August 18, 2020). Available at <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>; United Nations Office of the High Commissioner for Human Rights, *Disproportionate impact of COVID-19 on racial and ethnic minorities needs to be urgently addressed* (June 2, 2020); "About 40% of U.S. coronavirus deaths are linked to nursing homes," *New York Times* (September 16, 2020). Available at <https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html>; R. Ostriker, "More women than men are dying of coronavirus in Massachusetts. Why is that?," *Boston Globe* (May 16, 2020). Available at <https://www.bostonglobe.com/2020/05/16/nation/unlike-much-country-massachusetts-more-women-than-men-are-dying-coronavirus/>.
25. Global Health 50/50, *COVID-19: Age and sex data* (June 17, 2020). Available at <https://globalhealth5050.org/covid19/age-and-sex-data/>; K. Khyum Tithila and H. Mustazir, "4 in 5 covid-19 victims in Bangladesh are male," *Dhaka Tribune* (July 15, 2020). Available at <https://www.dhakatribune.com/health/coronavirus/2020/07/15/covid-19-bangladesh-reports-33-new-deaths-3-533-cases-in-24-hrs>; "69% of covid victims in India are men: Govt," *Times of India* (August 26, 2020). Available at <https://timesofindia.indiatimes.com/india/69-of-covid-victims-in-india-are-men-govt/articleshow/77753093.cms>; W. Joe, A. Kumar, S. Rajpal, et al., "Equal risk, unequal burden? Gender differentials in COVID-19 mortality in India," *Journal of Global Health Sciences* 2/1 (2020).
26. S. S. Bhopal and R. Bhopal, "Sex differential in COVID-19 Mortality varies markedly by age," *Lancet* 396/10250 (2020), pp. 532–533; A. Moeser, "COVID-19 affects men more than women and this could be the reason why, according to scientists," *World Economic Forum* (June 16, 2020). Available at <https://www.weforum.org/agenda/2020/06/covid19-mortality-rates-men-women/>.
27. United Nations High Commissioner for Refugees (UNHCR), *UNHCR Bangladesh operational update, 1–31 October 2020* (November 12, 2020). Available at <https://reliefweb.int/report/bangladesh/unhcr-bangladesh-operational-update-1-31-october-2020>.
28. S. Truelove, O. Abraham, C. Altare, et al., "The potential impact of COVID-19 in refugee camps in Bangladesh and beyond: A modeling study," *PLOS Medicine* 17/6 (2020).
29. P. Lopez-Pena, C. Austin Davis, A. Mushfiq Mobarak, and S. Raihan, *Prevalence of COVID-19 symptoms, risk factors, and health behaviors in host and refugee communities in Cox's Bazar: A representative panel study* (May 11, 2020), p. 17.
30. *Ibid.*
31. Inter Sector Coordination Group, ACAPS, CARE, et al., *In the shadows of the pandemic: The gendered impact of COVID-19 on Rohingya and Host Communities* (October 2020). Available at https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/in_the_shadows_of_the_pandemic_gendered_impact_of_covid19_on_rohingya_and_host_communities_october2020_o.pdf.
32. R. Shahid and H. Samad, "The international community must do more to support Afghan and Rohingya refugees amid the COVID-19 pandemic," *Atlantic Council* (September 16, 2020). Available at <https://www.atlanticcouncil.org/blogs/new-atlanticist/the-international-community-must-do-more-to-support-afghan-and-rohingya-refugees-amid-the-covid-19-pandemic>; M. Mainul Islam and M. D. Yeasir Yunus, "Rohingya refugees at high risk of COVID-19 in Bangladesh," *Lancet Global Health* 8/8 (2020), pp. e993–e994.
33. UNHCR, *Pakistan: COVID-19 external update* (September 2020). Available at <https://reliefweb.int/sites/reliefweb.int/files/resources/Pakistan%20COVID-19%20>

External%20Update%20%23%209.pdf.

34. E. Leidman, A. Humphreys, B. Greene Cramer, et al., "Acute malnutrition and anemia among Rohingya children in Kutupalong Camp, Bangladesh," *JAMA* 319/14 (2018), pp. 1505–1506.
35. Deepa Handu, L. Moloney, M. Rozga, and F. W. Cheng, "Malnutrition care during the COVID-19 pandemic: Considerations for registered dietitian nutritionists," *Journal of the Academy of Nutrition and Dietetics* (May 14, 2020); T. I. Hariyanto and A. Kurniawan, "Anemia is associated with severe coronavirus disease 2019 (COVID-19) infection," *Transfusion and Apheresis Science* (August 28, 2020).
36. V. Beniwal, "The virus has made India's devastating gender gap even worse," *Economic Times* (June 26, 2020). Available at <https://economictimes.indiatimes.com/jobs/the-virus-has-made-indias-devastating-gender-gap-even-worse/articleshow/76637355.cms?from=mdr>.
37. "A day in the life of Munni Devi, child protection volunteer," *Aangan Newsletter* (July 1, 2020).
38. M. Toulemonde, *COVID-19 outbreak: Cox's Bazaar rapid gender analysis* (Inter Sector Coordination Group, UN Women, CARE, and Oxfam, May 6, 2020), p. 17.
39. UNHCR, *Bangladesh / refugee situation: COVID-19 response 16–31 July 2020* (August 10, 2020). Available at <https://reliefweb.int/sites/reliefweb.int/files/resources/78176.pdf>.
40. M. Chen and D. Doane, "Informality in South Asia: A review," WIEGO Working Paper (September 2008), p. 4.
41. Mitra and Srinivasan (see note 21).
42. ACAPS (see note 11).
43. A. Bhatia, A. Mahmud, A. Fuller, et al., "A rapid needs assessment among the Rohingya and host communities in Cox's Bazar, Bangladesh: A randomized survey" (April 15, 2018). Available at <https://doi.org/10.31219/osf.io/nbr3f>.
44. H. Barr, "I won't be a doctor, and one day you'll be sick": *Girls' access to education in Afghanistan* (New York: Human Rights Watch, 2017), p. 12.
45. W. Mehran, "Food discrimination against women in Afghanistan," Heinrich Boell Foundation (August 7, 2017). Available at <https://reliefweb.int/report/afghanistan/food-discrimination-against-women-afghanistan>.
46. N. Dixit, "For Rohingya refugees in India, even basic nutrition services are a distant dream," *Wire* (February 5, 2018). Available at <https://thewire.in/health/rohingya-refugees-india-even-basic-nutrition-services-distant-dream>; N. Altijani, C. Carson, S. Sanyal Choudhury, et al., "Stillbirth among women in Nine States in India: Rate and risk factors in study of 886,505 women from the Annual Health Survey," *BMJ Open* 8/11 (2018).
47. European Asylum Support Office, *Pakistan: Situation of Afghan refugees* (May 2020), p. 47.
48. S. Purdin, T. Khan, and R. Saucier, "Reducing maternal mortality among Afghan refugees in Pakistan," *International Journal of Gynecology and Obstetrics* 105/1 (2009), p. 82.
49. S. Ijaz, "Closing Pakistan's maternity wards puts women at risk," Human Rights Watch (May 9, 2020). Available at <https://www.hrw.org/news/2020/05/09/closing-pakistans-maternity-wards-puts-women-risk>.
50. Bhatia et al. (see note 43).
51. G. Agamben, *State of exception* (Chicago: University of Chicago Press, 2005).
52. "Afghan refugees Camps in Nowshera, Lower Dir Sealed," *MENAFN* (April 9, 2020). Available at <https://menafn.com/1099995897/Pakistan-Afghan-refugees-camps-in-Nowshera-Lower-Dir-sealed>.
53. L. Kiss, L. Blima Scraiber, L. Heise, et al., "Gender-based violence and socioeconomic inequalities: Does living in more deprived neighbourhoods increase women's risk of intimate partner violence?," *Social Science and Medicine* 74/8 (2012), p. 1173.
54. Toulemonde (see note 38), p. 17.
55. Ibid.
56. UNHCR, *Bangladesh* (see note 39).
57. UNHCR, *Submission by the United Nations High Commissioner for Refugees (UNHCR) for the Office of the High Commissioner for Human Rights' Compilation Report – Universal Periodic Review: Bangladesh* (October 2012), p. 6.
58. UNHCR, *2019 Joint response plan for Rohingya humanitarian crisis* (February 2019).
59. Human Rights Watch (see note 10).
60. ACAPS and International Organization for Migration, *Different and unequal: How COVID-19 affects different sex, age, ability and populations differently* (April 27, 2020). Available at <https://reliefweb.int/report/bangladesh/covid-19-explained-different-and-unequal-edition-5-27th-april-2020>.
61. Ibid.
62. D. Jose, "India in lockdown: NGO workers face police brutality while helping poor in Hyderabad," *New Indian Express* (March 27, 2020). Available at <https://www.newindianexpress.com/cities/hyderabad/2020/mar/27/india-in-lockdown-ngo-workers-face-police-brutality-while-helping-poor-in-hyderabad-2122126.html>.
63. UNHCR, *Bangladesh* (see note 39).
64. Toulemonde (see note 38), p. 10.
65. "Rohingya refugee camps in Bangladesh put under 'complete lockdown,'" *Hindu* (April 10, 2020). Available at <https://www.thehindu.com/news/international/covid-19-rohingya-refugee-camps-in-bangladesh-put-under-complete-lockdown/article31307803.ece>.
66. R. Ratcliffe and R. Ahmed, "Bangladesh urged to lift Rohingya internet ban as Covid-19 rumours swirl," *Guardian* (June 11, 2020). Available at <http://www.theguardian.com/world/2020/jun/11/internet-ban-sparks-covid-19-rumours-in-rohingya-camp>.
67. Human Rights Watch, *Bangladesh: Internet ban risks Rohingya lives* (March 26, 2020). Available at <https://www.hrw.org/news/2020/03/26/bangladesh-inter->

net-ban-risks-rohingya-lives.

68. CARE and UN Women, *The COVID-19 outbreak and gender: Regional analysis and recommendations from Asia and the Pacific* (May 2020), p. 2.

69. CCHN, "Protection risks during COVID-19 in the Rohingya refugee response," *Frontline Negotiations* (July 15, 2020). Available at <https://frontline-negotiations.org/2020/07/protection-risks-during-covid-19-negotiating-safe-access-to-gender-based-violence-services-in-the-rohingya-refugee-response-in-coxs-bazar-bangladesh/>.

70. N. Jaiswal, "Preying on disaster: How human trafficking has spiked in quake-shattered Nepal," *New Humanitarian* (April 26, 2017). Available at <https://www.thenewhumanitarian.org/feature/2017/04/26/preying-disaster-how-human-trafficking-has-spiked-quake-shattered-nepal>.

71. E. Labott, "Recession boosts global human trafficking, report says," *CNN* (June 16, 2009). Available at <https://edition.cnn.com/2009/US/06/16/human.trafficking.report/>.

72. M. Mishra, "Trafficking of women in South Asia: A sketch," *Contributions to Nepalese Studies* 29/1 (2002), p. 134.

73. R. Mitra, "How the crisis of identity has followed the Rohingya to India," *Wire* (January 13, 2020). Available at <https://thewire.in/rights/rohingya-delhi-caa-nrc>.

74. *Ibid.*

75. R. S. Srivastava, "Bonded labour in India: Its incidence and pattern," working paper, Special Action Programme to Combat Forced Labour (2005).

76. N. Mohan, "Delhi HC rejects petition asking COVID-19 packages for Rohingya refugees," *Zee News* (May 9, 2020). Available at <https://zeenews.india.com/india/delhi-hc-rejects-petition-asking-covid-19-packages-for-rohingya-refugees-2282363.html>.

77. UNHCR, *UNHCR rolls out emergency cash assistance in Pakistan to help refugees impacted by COVID-19* (May 28, 2020). Available at <https://www.unhcr.org/asia/news/press/2020/5/5ecfda5f4/unhcr-rolls-out-emergency-cash-assistance-in-pakistan-to-help-refugees.html>.

78. Human Rights Watch, *Bangladesh: Covid-19 aid limits imperil Rohingya* (April 28, 2020). Available at <https://www.hrw.org/news/2020/04/28/bangladesh-covid-19-aid-limits-imperil-rohingya>.

79. Bhatia et al. (see note 43).

80. Toulemonde (see note 38), p. 10.

81. "Mizoram: 12 suspected Rohingya, believed to be trafficking victims, detained by police," *Scroll* (May 7, 2019). Available at <https://scroll.in/latest/922636/mizoram-12-suspected-rohingya-believed-to-be-trafficking-victims-detained-by-police>.