Health Problems and Health Care Seeking Behaviour of Rohingya Refugees

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Abstract

Background: Rohingya refugees are one of the most vulnerable group due to lack of health care system, personal hygiene, shelter, sanitation and violence.

Aim: The present study aims to find out the health problems and health care seeking behavior of Rohingya Refugees, to identify the socio-demographic information for such exposure group in relation to age, sex, occupation, living areas, to explore the patient's physical, emotional, perceptions, attitudes and environmental health problems and to bring out health care seeking behavior of refugees.

Methodology: A cross-sectional study was conducted. A total of 149 samples were selected conveniently for this study from the refugee camps. Data was collected by using mixed type of questionnaire. Descriptive statistic was used for data analysis which has depicted through tables, pie chart and bar chart.

Results: The finding of the study showed that 45.6% participants had multiple problems, followed by 16.8% participants who had other specific problems like musculoskeletal pain, visual problems and peptic ulcer. Urinary tract infection was the leading individual health problem with 11.4% of the sample group having it. 10.7% participants had hypertension, 6% had respiratory tract infection, 3.4% had nutrition deficiency, 4.75% had diabetes mellitus and 1.3% had sanitation & hygiene problems. Among the participants, 68.4% age ranged between 15-59 years. The study showed that, only 16.1% participants were satisfied with the quality of service they received while 37.6% participants said that they needed better services such as more laboratory test, radiological imaging, more medicine and more doctors.

Conclusion: It is clear that refugees suffered from a variety of health problems, because their living condition and environmental situation were not similar like an independent nation. Further, basic amenities like medicines and other services were not available.

Keywords: Health problems, Rohingya refugee, Health seeking behaviour, Bangladesh.

Introduction

Rohingyas are an ethnic, linguistic and religious minority group of Northern Rakhine State (NRS) of Myanmar. Myanmar government categorized them as illegal immigrants from Bangladesh and have been excluded from citizenship and basic human rights [1]. From 1991-1992 a mass exodus of more than 250,000 Rohingya refugees fled persecution in the Union of Myanmar and arrived in Bangladesh, living in temporary camps and completely dependent on outside support from the United Nations (UN), the Government of Bangladesh (GOB) and numerous non-governmental organizations (NGOs) [2,3,4]. Globally, the total population of refugees is about 9.9 million. The general health status of refugees in various countries is reported to be poor with malnutrition being the major health problem due to lack of access to sufficient food and nutrient intakes. Other health problems among refugees include mental illnesses, intestinal parasites, hepatitis B, tuberculosis, sexually transmitted diseases, HIV/ AIDS, malaria and anemia [2,5]. Infants and young children are often the earliest and most frequent victims of violence, disease, and malnutrition which accompany population displacement and refugee outflows. One of them said "My life is over. All I want is, for my children to have a chance at a better life." Two generations of the Rohingya have said this. The vast majority of their community suffers the same

neglect and lack of opportunity that their parents faced at present, there are no specific services available to refugee children with special needs or disabilities. With regards to cases of sexual exploitation of children, there have been reports and cases of refugee minors (females) being harassed, abused or raped by local villagers. A survey found that out of 508 children of under 5 years of age, 65% were anemic and therefore, chronically malnourished (4, 6, 7). Rohingya is an ethic group of people referring from the Sunni Muslim dwelling from Arakan, the historic name of border region of Myanmar which has a long history of apartness from the rest of the country. In general, Rohingya are of mixed tribe, who have traxces from their generation from ancestry (Arabs, Moors, Turks, Persians, Moguls and Pathans) and also from local Bengali and Rakhine. They speak Chittagonian (a local language style), a regional idiom of Bengali which is also used extensively throughout south-eastern Bangladesh [8].

Basic services like shelter, nutrition, education, medication and health care are needed for Syrian refugees. Near about 1.4 million Syrian refugees are children, United Nations Children's Fund has showed that these children are at risk of being a "lost generation". Syrian refugees tolerate daily physical and mental survival-challenge. In the case of extreme needs for physical and nutritional interventions, mental health professionals find out the emergency needs for counseling services based on comprehensive documented reports of refugees [9,10].

Three meals a day were served in camps, but refugees were not satisfied with the quality of what was being served. There were occasional cases of food intoxication. Refugees were not allowed to cook their food in tents because of the risk of fire. Out of camps, the nutritional status of refugees is mostly bad and only limited number of them could have 3 meals a day. In general, they fed on bread and vegetables. A survey conducted at a provincial centre found, among women in the age group 15-49, iron (by 50%) and B12 vitamin deficiency (by 46%) [11]. Some of the countries in the region (notably Pakistan, Bangladesh, and Nepal) hosted the refugees and displaced populations from neighbouring states, a circumstance that in itself merits attention since it has the potential to cause major political unrest [12]. Myanmar is a High HIV prevalence neighboring country of Bangladesh. A small town Teknaf is in the Chittagong Division situated at the southern tip of Bangladesh. It separates Bangladesh and Myanmar from the eastern side. Tens of thousands of refugees are currently living in poverty-stricken conditions at the Bangladeshi side [13].

A 19 years old refugee at Nayapara camp sayed that "I was born in Burma, but the Burmese government says I don't belong there. I grew up in Bangladesh, but the Bangladesh government says I cannot stay here. As a Rohingya, I feel I am caught between a crocodile and a snake" [14]. The population of Bangladesh is growing at an approximately rate of l.59 percent per annum which includes 27% in the urban areas while that of rural is 73%. Bangladesh's population growth rate was among the highest in the world in the

1960s and 1970s, when the country swelled from 65 to 110 million [15]. The problem of Rohingya refugee has been a chronic issue that involves the question of an ethnic minority's identity. In Myanmar, the Rohingyas are an ethnic minority group in the northern Arakan (currently known as Rakhine). From the eleventh century to 1962, the Rohingyas trace their historical roots in the Arakan region commonly known as Muslim Arakanese [16]. More than Hundreds of Rohingya have been the victims of torture, despotically binding, rape, sexual harassment and other forms of serious physical and mental harm, Rohingya have been fully devoid of freedom of movement and access to food, clean drinking water, sanitation, medical care, work opportunities, and education [17]. There is no domestic law in Bangladesh to regulate the administration of refugee affairs or to guarantee refugee rights. New refugees have difficulties accessing health care, their health problems may worsen with time.5 Social isolation and disconnection have been shown to contribute to premature death among members of isolated communities [18].

In refugee camps, medical services are mostly crippled as there is no examination and with the exception of some community health centers (RHU) there is no pregnant women and infant monitoring either, since family planning services for refugees are not available, there are unwanted births and increase in infant mortality, women additionally face risks of gender discrimination, sexual violence, early marriage and miscarriage and birth complications [19]. The government of Bangladesh showed their warm welcome to the Rohingyas from beginning and made corporeal efforts to accommodate them but the GOB had clearly maintained from the beginning that shelter for the refugees was temporary and encouraged them about their immediate return, In 1992 in south–western area, 20 refugee camps were constructed in Bangladesh for refugees. Among them, only few have been persisted till now which are as named Nayapara and Ukhia. Nayapara refugee camp is situated at Teknaf and Kutupalong refugee camp near Ukhia, giving shelter to 21,621 refugees, and also Kutupalong camp officially houses 8,216 refugees and Nayapara 13,405 (as of recorded till December 2001) [20)].

Methods

Study Place

The study was conducted at the refugee camp in Cox's Bazar in Bangladesh.

Data Collection, Management & Analysis

The data was collect from the refugee camp in Cox's Bazar in Bangladesh through a standard mixed type questionnaire. The study was conducted at the Nayapara refugee camp at teknaf in Cox's Bazar. About 149 samples were collected from July 2016 to October 2016 in Nayapara refugee camp by convenient sampling. After collecting the data analysis is done by SPSS (Statistical Package of Social Science) software version 16.0.

Ethical consideration

A research proposal was submitted to the public health department of ASA University for approval and the proposal was approved by the faculty

members and gave permission initially from the supervisor of the research project and from the academic coordinator before conducting the study. The necessary information has been approved by the ethical committee of public health department and was permitted to do this research. Also the necessary permission was taken from the Camp In charge (CIC), health coordinator & medical team leader of the refugee health unit (RHU). The participants were explained about the purpose and goal of the study before collecting data from the participants. Pseudonyms were used in the notes, transcripts and throughout the study. It was ensured to the participants that the entire field notes, transcripts and all the necessary information was kept in a locker to maintain confidentiality and all information was destroyed after completion of the study. The participants were also assured that their comments will not affect them in any way possible.

Result

Among 149 participants, 82 (55%) were female and 67 (45%) were male. Female were predominantly higher than male. Mean age of the participants was 45.52 (±19.28) years, mode was 35. The range is 100 with minimum age 02 years and maximum 102 years. Among the participants the higher numbers of the participants were at the age of 35 years and the numbers were 13 (8.7%). The number of ≤ 18 years were 15 (10.1%), ≤60 years were 102 (68.4%) and ≥60 were 32 (21.5%). Majority of the participants were illiterate the numbers were 112 (75.2%) and 37 (24.8%) participants were literate those who complete their primary education. Majority of the participants were married the numbers were 105 (70.5%) followed by those who are widow the numbers were 24 (16.1%) and 20 (13.4%) participants were married. Nuclear family were 76 (51%) whereas 72 (49.0%) participants were in extended family. Among total particepants housewife were 61(40.9%), Unemployed were 42 (28.2%), others 16 (10.7%), student 13(8.7%), Day labour 11(7.4%), Agriculture 3(2%) Driver2 (1.3%) and Fisher man1 (0.7%) (Table 1).

The mean of the number of problems faced was 7.39 with standard deviation (± 3.28), median being 9.0 and the mode was 10. Out of the 149 participants, 68 participants (45.6%) had multiple problems followed by 25 participants (16.8%), who had other specific problems like musculoskeletal pain, visual problems and peptic ulcer. Urinary tract infection was the leading individual health problem {17 participants (11.4%)}, 16 (10.7%) participants had hypertension, 9 (6%) had respiratory tract infection, 5 (3.4%) had nutrition deficiency, 7 (4.75%) had diabetes mellitus and 2 (1.3%) had sanitation & hygiene problems (Figure 1).

82 (55%) participants took medicine from RHU, 49 (32.9%) received multiple services like medicine, referral, laboratory test & others { 5 (3.4%)} received both laboratory test and referral to other organizations & 6 (4%) participants said that they didn't received any treatment from health center. Majority {75 (50.3%)} of the participants said that they received health services from RHU, followed by those who received health services from multiple organizations like RHU, HI, ACF & RTMI and 6 (4%) said that

Demographic Variable			
Gender	Gender	Frequency	Percent
	Male	67	45
	Female	82	55
Age	Age	Frequency	Percent
	01-10	06	4.0
	11-20	10	6.7
	21-30	14	9.3
	31-40	35	23.5
	41-50	29	19.5
	51-60	23	15.4
	61-70	18	12.1
	71-80	10	6.7
	81-90	2	1.4
	91-100	1	0.7
	101-110	1	0.7
Educational Status	Educational level	Frequency	Percent
	Illiterate	112	75.2
	Literate	37	24.8
Marital Status	Marital Status	Frequency	Percent
	Married	105	70.5
	Unmarried	20	13.4
	Widow	24	16.1
Occupations of the Participants	Occupation	Frequency	Percent
	Fisher Man	1	.7
	Agriculture	3	2.0
	Driver	2	1.3
	Day laborer	11	7.4
	unemployed	42	28.2
	Housewife	61	40.9
	Student	13	8.7
	other (Specify)	16	10.7

Table 1: Distribution of demographic variables

they received services from others like MSF, health complexes.

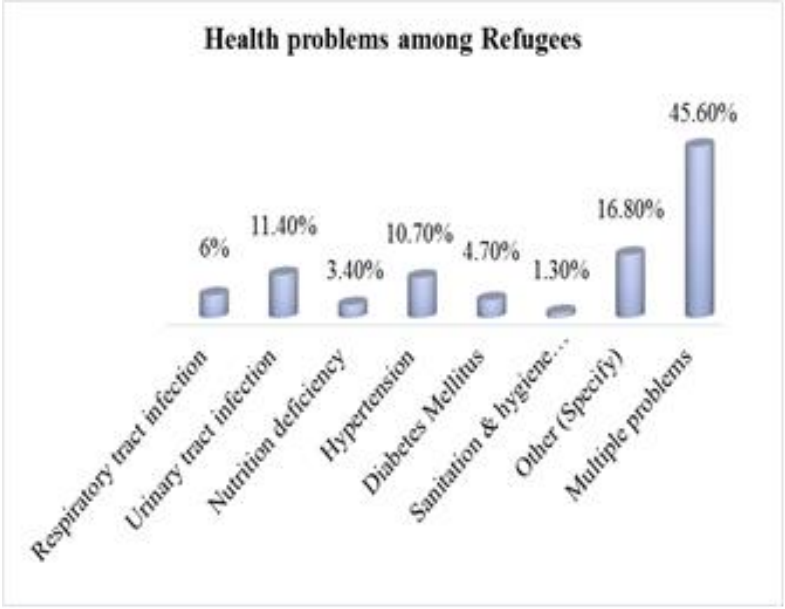

Figure 1: Health problems among the participants (n=149)

Among the 149 participants, only 11.4% (n=17) participants said they have enough health services to meet their needs, 58.4% (n=87) said that sometimes they have enough health services to meet their needs and 30.2% (n=45) said that they did not not enough health services. Majority (n=50, 33.6%) of the participants said they didn't meet needs because there was a lack of medicine supply and doctors in the camps. 47 (31.4%) of the patients said that they didn't meet needs because there is a lack of medicine supply in camps (Table 3).

Among the 149 participants, 56 (37.6%) participants said that they need better services. Majority of the participants said that they need multiple services includes more laboratory test, radiological imaging, more medicine & more doctors, 17 (11.4%) participants said that they need more medicine and 3 (2%) said that they require more referral, laboratory test and radiological imaging.

Type of health care	Frequency	Percentage
Medicine	82	55.0
Counseling	2	1.3
Laboratory test	5	3.4
Referral	5	3.4
Nothing	6	4.0
Multiple Services	49	32.9
Health care receive organization	Frequency	Percentage
Refugee Health unit (RHU)	75	50.3
Handicap International (HI)	1	0.7
Others	6	4.0
Multiple Organizations (RHU, HI, ACF, RTMI)	67	45

Table 2: Type of health care and health care receive organization (n=149)

Among the 149 participants, only 16.1% (n=24) participants were satisfied with the quality of service received, 56.4% (n=84) said that they were sometimes satisfied after receiving the services and 27.5% (n=41) denied of being satusfied even after receiving it.

Health care services that meet the demands	Frequency	Percent
Yes	17	11.4
No	45	30.2
Sometimes	87	58.4
Reason that not fulfill the demands	Frequency	Percent
Not enough medicine supply in the camps	47	31.4
Narrow space in health unit	5	3.4
Lack of doctors	25	16.8
Other	5	3.4
Not enough medicine & Lack of doctors	50	33.6

Table 3: Health care services that meet the demands and the reason for not fulfill the demands (n=149)

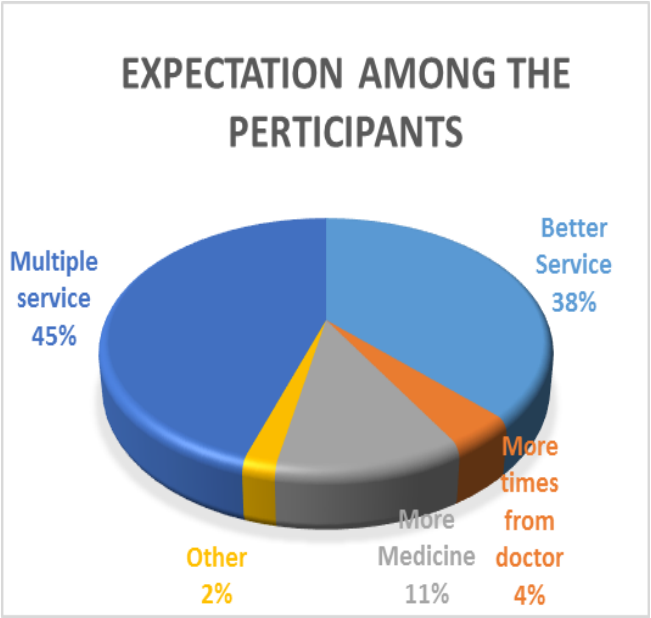

Figure 2: Expectation among the participants (n=149)

Figure 3. Satisfaction level among the participants (n=149)

Discussion:

The result of this study showed that 45.6% participants were having multiple problems followed by 16.8% participants who had other specific problems like musculoskeletal pain, visual problems and peptic ulcer. Urinary tract infection was the leading individual health problems (11.4% had it), while 10.7% participants had hypertension, 6% had respiratory tract infection, 3.4% had nutrition deficiency, 4.75% had diabetes mellitus and 1.3% had sanitation & hygiene problems during the course of the study. It was also observed that among the participants the mean age of the participants was 45.52 (±19.28) years. The range is 100 with minimum age pf 2 years and maximum 102 years. Among the participants, the higher numbers of the participants were at the age of 35 years (8.7%). The numbers of ≤ 18 years were 10.1%, ≤60 years were 68.4% and ≥60 were 21.5%, the middle age people were the ones which had maority of the health problems. Önen C et al stated that health problems among refugees were frequently seen mostly at the early childhood & in adult aged problems, a community based study was carried out by Turkish medical association stated that 25.0% children had sleeping disorder at the of below 18 years & 24.0% have adult persons with the same problems [22].

The study showed that, majority of the participants received health services from RHU {75 (50.3%)}, followed by other multiple organizations like RHU, HI, ACF & RTMI and 6 (4%) said that they received services from others like MSF and health complexes.

The study showed that, only 16.1% participants were satisfied with the quality of service they received, 56.4% said that they were sometimes satisfied after receiving services while 27.5% were not satisfied. Among the 149 participants, 32.9% participants said that they were not satisfied because there is a lack of medicine supply in RHU, 13.4% participants were not satisfied because there is a lack of qualified doctor in RHU & 38.9% participants stated that in RHU there wass a lack of budget, lack of doctor, lack of medicine supply, lack of referral to other organization in timely, not gave proper medicine & treatment & lack of serial maintain during medicine collection.

Conclusion

Rohingya refugees are far away to achieve their basic human rights and they have become stateless without a legal nationality from 1962. Considering the importance of nationality crisis of the Rohingya and problems associated with these following steps can be taken: Supplies of adequate Medicine, Increase Doctors' and Nurse, Modernized treatment, Increase Childcare hospital, Decrease pollution, Mass awareness of life threatening disease.

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