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How Healthy Are Rohingya Refugees in Bangladesh after Two Years of Influx?

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Abstract
Background: Rohingya refugees, a vulnerable group living in Bangladesh since the early 90's. Because of the massive ethnic cleansing in August 2017, they were again forcibly displaced from the Arakan State of Myanmar and took shelter in Bangladesh in a gigantic number. The objective of this research was to identify the current situation of health, nutrition and water and sanitation of the Rohingya refugees residing in camp no 10 & 18.
Materials and Methods: Retrieving of data from the refugees were challenging and therefore, the researchers selected FGD method which seemed to be more suitable. Five FGDs (two from the refugees of camp no 10, two from the refugees of camp no 18 and one from host community) carried out for this study to obtain the study objectives.
Results: The study findings confirmed that the refugees were struggling to ensure their basic needs in their everyday life. The Rohingya people were compelled to led an unhygienic way of life due to the overpopulated camp condition and most of the time suffered from cholera, diarrhea, typhoid, and other water borne diseases. Insufficient hospitals, made their lives miserable getting proper treatment for different diseases. HIV patients were increasing in an alarming manner which was becoming a first-rate danger for Bangladesh.
Conclusion: The refugees received free healthcare and medication (mainly primary treatment) from both camps and hospitals. The health care facilities were deficient with the increasing Rohingya population and they felt dissatisfied with the services they were receiving. The study advocated that both government of Bangladesh and NGOs ought to take necessary steps to overcome the challenges of the refugees and make their life better than the prevailing situation.
Key Word: Rohingya, Refugees, Health, WASH, Adolescents, Education, Shelter, Food.

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I. INTRODUCTION

The Rohingya are a Muslim ethnic minority group which have been persecuted for generations and forcefully displaced because of increasing violence in their place of origin in the Northern Rakhine state of Myanmar. According to the Myanmar Citizenship Law of 1982, Rohingya Muslims are considered to be "stateless" and "illegal immigrants". The procedure of "othering," discriminatory treatment, and "ethnic cleansing" of the Rohingya people in Myanmar is well recognized and goes back for decades (Mahmood, Wroe, Fuller, & Leaning, 2016) (Sen, 2008) ((MSF), 2013) . The Rohingya have met a continuing condition of severe and systemic oppression characterized by the absence of freedom of movement, inadequate access to sufficient food, insufficient health care, and constrained educational and livelihoods opportunities (ACAPS, 2017) (Myanmar, 2018).

An approximately 693,000 Rohingya people fleeing violence in Myanmar's Rakhine state have crossed the border into Bangladesh since the end of August 2017. These contained 585,000 in the Kutupalong Expansion site, 237,000 in different settlements and camps, and 79,000 in host communities, who've joined another 213,000 Rohingya people already in Bangladesh following previous waves of displacement. While the mainstream of the refugees was residing in Kutupalong and Balukhali mega camps and a few other clusters of small and big settlements, around 79,000 were living with the host population. The mega camps are currently one of the world's largest refugee settlements and also one of the world's greatest densely populated areas. As of January 2019, over 900,000 stateless Rohingya refugees reside in Ukhiya and Teknaf Upazilas. The huge majority lives in 34 extremely congested camps. The largest single site, the Kutupalong-Balukhali Expansion

Site, hosts around 626,500 Rohingya. While maximum arrived between August and December 2017, arrivals have continued since then: more than 16,000 Rohingya have arrived since January 2018 (ISCG, 2018).

From the outset of the crisis, the Government of Bangladesh has protected the lives of nearly one million Rohingya refugees by keeping its borders open and leading the humanitarian response in close collaboration with the humanitarian community. In support of government efforts, the humanitarian community promptly scaled up operations to provide life-saving protection and support to both Rohingya and Bangladeshis in affected host communities. In campsite Men and women have received primary health care facilities at the side of curative and preventive aid capabilities. However, children have suffered from the results of open sewers and substandard sanitation within the camp and from deficiency disease because of inadequate food rations. Women have typically hesitated to use substandard sanitation. Women additionally expertise the damaging health effects of early wedding and teen gestation within the camp, though this can be additionally common in Bangladesh society (Prodip, 2017). However, infrastructure has been placed into make sure sanitation within the camp once the 1992 crisis. Indeed, NGOs enforced sanitation measures in each block within the official camp (17 units of 5 latrines). Although, UNHCR was working on their sanitation plan. Their objective was to implement sanitation for 250,000 inside successive six months. Encouraging sensible hygiene practices and raising awareness on this issue among refugees were economical tools to boost life quality relating to sanitation. This range has since gone up, due not solely to the magnified range of people among the neighborhood however conjointly as tubes close to the boundaries of the official camp are being employed by those within the extended areas. These tubes required way more maintenance and camp officers have enforced a management programme, through those locals were paid in rice to repair and maintain the tube wells. Moreover, different programmes were in the process of being enforced likewise, like 3 new water purification facilities and fresh water assortment initiatives. In addition, some locals had taken the initiative to dig their own wells. Whereas this will not give them with appropriate water, it will fulfill their bathing and improvement needs (Sikder, 2010).

As it is known that refugees do not get sufficient facilities as like the general people but still they get the facilities to fulfill their basic needs, this study was conducted to identify how healthy are Rohingya refugees in Bangladesh after two years of influx. Additionally, some data were collected from the host community to analyze the situation from their aspects.

The world's largest refugee camp is located Kutupalong. Nearly a million Rohingya refugees are crammed into this region. Kutupalong continues on and on, the bamboo latticed tarp shelters carpeting the rolling hills of this former forest preserve. Though GoB, INGOs and NGOs helped the Rohingya refugees who fled to Bangladesh in 2017, they faced several challenges to ensure their basic needs. After two years, some improvements in their former scenario became apparent. The goal of this study was to perceive the scenario of the Rohingya refugees in terms of health, WASH in Kutupalong camps no 10 & 18 after two years of their recent influx.

II. MATERIAL AND METHODS

The vast majority of the Rohingya who show up are situated in two upazilas in Cox's Bazar region: Ukhia and Teknaf. The Kutupalong campground in Ukhia upazila is viewed as the biggest Rohingya camping area in Bangladesh. There were 34 Rohingya camps, and each camp consisted of many blocks. The purpose of this study was to identify the condition of Rohingya refugees living in camps 10 and 18 in Kutupalong.

Study Design: In order to describe the condition of the most heavily inhabited camps on earth, the analysis adopted a qualitative research approach.

Study Location: For the selection of the camps where camps No 10 & 18 were selected from the 34 Rohingya camps, a simple random sampling was carried out to identify.

Study Duration: The data was gathered by the researcher for seven days in January 2020.

Sample Size: For each FGD, 6 participants were picked purposively.

Subjects and Selection Method: For the selection of FGD participants, the researcher pursued a purposive sampling procedure both for the Rohingya and host community.

Procedure Methodology: For data collection, a FGD checklist was created and planned. The researchers followed five focus group discussions, two from camp 10, two from camp 18 and one from host community for better understanding of the condition of the Rohingya refugees from both the displaced and host populations. For the collection of FGD participants, the researcher pursued a purposive sampling procedure. Although the participants were selected purposively, there were no biasness in gender selection. The refugee women were timid and unwilling to engage in FGDs, so lion share of the participants was male. Secondary data were also obtained through a variety of related documents, journals, studies, newsletters, booklets and websites, and so on to provide the analysis with a logical context. The entire procedure was accompanied by qualitative methods for assessing and evaluating the observations and finished in the light of the objective.

III. RESULT

Several health-related concerns have been found when conducting research. Different diseases such as cholera, typhoid, diarrhea and contagious diseases such as scabies etc. have affected Rohingya family members. While primary medications were obtained from camp doctors, care was not adequate due to the number of patients and diseases. Each camp consisted of at least one hospital with at least one emergency department, an intensive care unit, a medical laboratory, an inpatient division for adults and infants, a maternity unit with a neonatal care unit, an insulation unit for patients with communicable diseases and an intensive therapy unit feeding center for chronically malnourished children and the residents in that particular camp obtained free hospital care and medications. Sometimes, through free health care services, a substantial percentage of refugees have paid for health care. The economic resources needed for access to healthcare are likely to derive from loans that allow donations to refugees incurring debt. However, they had to go to Cox's Bazar General Hospital for more vicious and infectious diseases. The closest medical center was less than 30 minutes away from their home. People who wished to get access to antenatal services did not have any issues at all.

Vaccination services were also offered, particularly for children and women, and often children obtained nutritional supplements from various NGOs such as the WFP, UNHCR, USAID, etc. In addition, pregnant women got care before giving birth, but the issue was that they did not remain in hospital for longer than two days after giving birth due to lack of seats. In case of an emergency, mother and children were moved to Kutupalong Hospital or Cox Bazar Hospital. If, after recovery, they had faced some sort of health issues, they had to go to the hospital again. Pregnant & lactating women (PLW) and children are provided with nutritious alternatives such as Super Cereal Plus, a mix of wheat soya (WSB) from UNICEF, WFP, USAID, etc. In addition, HIV infection among Rohingya refugees has increased due to social stigma and lack of awareness. Respondents indicated that the doctors were polite and well educated. They examined both patients very closely. Patients have been inspected for a long time if possible for a better diagnosis. The refugees followed the orders and medications that the doctors had given them.

The WASH field representing the water and sanitation system was objectively regarded by the respondents. This study established an unsatisfactory water and sanitation scheme at the Rohingya camp level. People had to obtain drinking water from safe tube-wells, but it was not enough for the number of tube wells. There were more than 200 families in each block and there were just 2-3 tube wells per block, which seemed to be too inadequate for them. Moreover, there were no secondary or other sources of drinking water, so they had to rely on tube wells only as a source of drinking water for cooking and washing. But NGOs checked the water in some tube wells and warned them that the water in the tube wells contained arsenic so that they could be identified as red. Often the water deformed and caused multiple diseases such as cholera, typhoid, etc. Both adult males and females gathered water for their home, although most of the time women did this job.

During the gathering of water, people faced numerous problems; for one, it took a long time to wait to gather water. The water supplies were too far away from the house, too. The road to the water supply was too steep, and it was also difficult to go to the water collection source because of the hilly area, and much of the time at night, it was almost impossible to gather water from sources. It took a very long time to gather water from the storage center. They could only get 4-6 jugs a day. The jug had 15 liters of water. Approximately 5 jugs of water were required in each household every day for drinking and cooking. Yet there were only fewer than 4 jugs. In other locations, it takes just 2-3 minutes to fill a container with water, but in 10 & 18 no camps it took about 15-20 minutes to fill a container of the same capacity. For that cause, water stays in the truck, and people behind it don't get water, so it was unavoidable to struggle for it. There are opportunities for campsite jobs, however, but they can't go and raise money while they wait to gather water. NGO volunteers instructed them to keep drinking water protected and wash their hands before and after a meal, after using latrines, and also store water in a higher position at home to keep away from the reach of kids. They administered some drugs to them and told them to combine them with their drinking water to combat germs. As a result, refugees used to drink water by combining these drugs. During the rainy season, the roads were muddy, so it was very difficult to cross the roads to gather water. Finally, in the rainy season, the water issue became less acute when they could gather water from rain.

There have also been problems with hygiene. Almost the whole time, it was crowded. There, physical access was challenging as they could not sit appropriately. Insufficient water was a concern there as well. Since it was used by many people, latrines were unhygienic. Everyone had access to latrines. Although often people tend to defecate outside. Latrine tanks were loaded and some latrines were shut down because they were completely filled. Some NGOs washed the latrines for them, but they filled the toilets with sand and soil at one point. So, the number of latrines went down. There were no appropriate lighting facilities around both latrines and bathrooms because there was no electricity. It was very challenging at night for the sick, the disabled, and the women to go to the toilet. Old people and ladies were met with difficulties using latrines when they were in the hilly area. This activity has led to unhygienic conditions in a congested area, such as the Cox Bazar camps.

IV. DISCUSSION

Health: As of January 2019, there were 158 health services, 27 health centers and 8 hospitals. While there was a surplus in health facilities, discrepancies remain in the availability of 24/7 services in primary health care centers (PHC). Currently, one PHC served a total of 54,000 refugees, while the standard was one PHC per 25.000 refugees.

About 90 per cent of Rohingya sought and received care while they were sick, with the vast majority using NGO clinics and health staff. Sometimes, notwithstanding the free availability of health services, a substantial percentage of refugees paid for medical attention. The financial services needed to obtain healthcare are likely to come from loans that allow donations to refugees incurring debt. Approximately 9 per cent of refugees who took a loan purchased medicines at pharmacies, while 6 per cent were pursuing private diagnostic and care services. An additional 12 per cent paid for travel to government services outside the camps. According to the Multisector Needs Assessment (MSNA) 2019, the main issues surrounding access to health care included unavailable equipment, inaccessible medication, teeming hospitals and long distances to medical facilities (UNHCR & WFP, UNHCR-WFP Joint Assessment Mission (JAM) Report 2019 Cox´s Bazar, Bangladesh, 2019).

The 10-bed Health Center was funded by the UNHCR, the UN Refugee Agency and the UN Population Fund. It was managed by local collaborators, Research, Training and Management International, or RTMI, and Gono-Shasthaya Kendra (GK). The clinic was considered one of nine UNHCR-supported primary health centers that were open 24 hours a day, seven days a week, offering life-saving services to Rohingya refugees. An additional 14 health posts offered daytime care and transfers to hospitals. UNHCR funded the number of primary health care facilities that offered 482,000 refugee consultations at settlements in 2018, free of charge. The Organization and its allies have trained 309 refugees as volunteer community health workers who went house to house to raise awareness of health and nutrition issues. The major breakthrough was the extension of programs at night to include emergency coverage. It was funded by a round-the-clock ambulance service to transport seriously injured refugees to emergency care outside the refugee settlements, accessible via patient referrals. However, with the assistance of UNHCR, expenses incurred in facilities outside the camp is covered (UNHCR, Saving lives at the world's largest refugee camp, 2019).

Médecins Sans Frontières (MSF) International has opened a new hospital in the heart of the massive Kutupalong-Balukhali camp, providing shelter to some 700,000 Rohingya refugees in Bangladesh. It was the third MSF facility that had been opened in Cox's Bazar district since the end of March 2020. The hospital had an emergency room, an intensive care clinic, a surgical laboratory, an inpatient department for adults and infants, a maternity unit with a neonatal care unit, an insulation unit for patients with infectious diseases and an advanced therapeutic feeding program for chronically malnourished children. The new hospital offered a wide variety of medical and family planning facilities for women. However, the new hospital often promised to treat chronic diseases such as hypertension, chronic obstructive pulmonary disease and asthma, diabetes, etc. attributable to stagnant water retention, water-borne diseases such as cholera, hepatitis E that also spread (Médecins Sans Frontières, The hospital on the hill providing care to Rohingya refugees, 2018).

Sexual and Reproductive Health: In view of the severity of the problem, UNFPA and other United Nations organizations, along with government and civil society agencies, are unable to address the increasingly growing call for services. UNFPA is the largest agency on the ground within the camp providing life-saving sexual and reproductive health programs. Acting with the Ministry of Health and Sport, UNFPA has sponsored the strengthening of exercise machines to boost chain management when turning commodities for rapid response, focusing on humanitarian-affected areas. In addition, UNFPA included the Minimum Initial Support Package (MISP) for reproductive health with the Ministry at the municipal level, improving efficiency and facilitating a better initial response by the prepositioning of supplies ((UNFPA), 2018). Women deliver at home several times in camps. In these situations, as women deliver at home, choices were minimal if anything went wrong. Since the camps have short roads, which are often muddy, it is impossible at night to transport pregnant women with complications to camp hospitals. As they sit home at night, they are either in very bad condition by the next day, or they bleed at home for days, and eventually arrive at the sepsis center. However, pregnant women have insufficient knowledge and access to antenatal care (ANC) and postnatal care (PNC) facilities. In addition, births of Rohingya babies in Bangladesh have not been registered since 2019-2020. The Rohingya children born here would have no birth certificates, no and no residency rights as refugees (Médecins Sans Frontières, Limited options: Pregnant women in Bangladesh's Rohingya refugee camps have little access to safe maternity care. MSF, 2019).

Adolescent Boys & Girls: Adolescents repeatedly and consistently highlighted markets as the most dangerous environments for them, as physical and verbal violence is widespread. However, they have revealed that slavery (including trafficking) is taking place, especially in markets where 'traffickers' are attempting to trap children with false promises of employment, as boys are needed for manual labor and girls are offered domestic jobs, which ends up becoming sexual exploitation. Teenagers became worried about younger] victims of opioid

violence and the prevalence of drug trafficking in camps and the home city. Adolescents have demonstrated increased understanding of psychosocial and leisure child safety programs in Child Safe Spaces (CFS) etc. However, less understanding of the provision of individual case management programs on more severe child protection issues (Save the Children, 2019).

Though most girls say they feel much better in Bangladesh than they did in Myanmar, there is still fear of violence between girls and the community. This insecurity hinders the trust in the rights of girls and further limits their freedom of movement and their access to education. While girls are aware of the health resources available to them and regularly seek out and obtain access to health care services, distance or lack of transportation to healthcare facilities, cost factors and the restricted supply of medication build barriers to health care. Of special concern is that very few girls have access to mental health facilities (Plan, 2018).

Prevalence of diseases: Médecins Sans Frontières (MSF) International treated 7,032 patients for diphtheria, 4,987 for possible measles and 99,681 for acute watery diarrhea between August 2017 and March 2019. Between August 2017 and March 2019, there were 1,242,500 outpatient consultations and 21,549 inpatient admissions, including caring for 7,032 diphtheria patients, 4,987 reported measles patients, 47,556 antenatal consultations, 2,750 births, 1,087 sexual and gender-based abuse casualties, and 25,679 persons and 41,480 community mental wellbeing consultations (Médecins Sans Frontières, Crisis Update May 2019, 2019).

HIV infections among Rohingya refugees have risen due to social stigma and lack of awareness. In the opinion of medical experts, Rohingya is increasingly prone to HIV and other STDs in Bangladesh. According to the latest BD government reports, 395 Rohingya dwellings in Cox's Bazar refugee camps have been infected with the deadly virus so far, with 105 new cases reported this year. The actual number of these inflamed individuals, the experts said, may be even higher than the official average. They advise the authorities to put steps in order to test the transmission of diseases. In all 319 cases of HIV, 277 took medicine and 19 died. However, many Rohingya still see HIV in the same vein as normal diseases such as cough or fever reported by a medical officer. Many international agencies provide HIV screening programs for patients. However, these screening facilities are not adequate to address the needs of about one million refugees in need of humanitarian assistance, experts said (Rafe, 2019).

WASH: In the 2019 UNHCR-WFP Joint Assessment Mission (JAM) report, it has been shown that health & WASH facilities have improved dramatically because the mortality rates have fallen below emergency levels. Water supplies are adequate in the Kutupalong camp but less than 15 liters per person per day than the registered Nayapara camp. Both organizations agreed to improve cooperation between the WASH, Nutrition and Food Security Units with a view to improving the relation between joint analyzes and information management for an integrated response (UNHCR & WFP, UNHCR-WFP Joint Assessment Mission (JAM) Report 2019 Cox´s Bazar, Bangladesh, 2019).

In camp 10 and 18 the latrines were too far from the house, and they were crowded. Latrines were unhealthful since they were used by a lot of people. Everyone had access to latrines, but often people opted to evacuate outside. Some of the latrine tanks were complete, and some latrines were shut down because they were fully loaded. Thus, the number of latrines was diminishing. In the other side, at night, people had to queue up to use the toilet, which causes multiple digestive issues and stomach pain. There were no appropriate lighting systems covering all the latrines, since there was no electricity. It was very painful at night for the sick, the disabled and the women to go to the toilet. In their shelters, women and girls were told to bathe in private, makeshift bathrooms. In a clogged area, such as the camps in Cox's Bazar, this activity has led to unhygienic conditions. More toilets for proper sanitation were needed by the people of those camps.

The respondents also indicated that the Rohingya camp's water and sanitation infrastructure wasn't safe enough. There were approximately 2 tube wells in each block. Since secondary water supplies were inadequate, they only had to rely on tube wells as a source of cooking and cleaning water for drinking. Some NGOs, on the other hand, tested the water of some tube wells and told them that the water contained arsenic in those tube wells, so that the water supplies were more limited. As the water supplies were so far away from the property, people encountered difficulties gathering water. The track to the water source was too vertical, and even going to the water collection source was dangerous because of the bumpy place, and most of the time at night, it was almost terrible to collect water from the wells. Even, the storage of water from the delivery site took a very long time. The jug had 15 liters of water in it. In each household, they need about 10 jugs of water every day. Yet they only earned fewer than six jugs. However, it takes just 2-3 minutes to fill a water vessel in other areas, but it took between 15-20 minutes to fill the same container in 10 & 18 no. camps. Water persists in the truck for that cause, because people who are behind do not get water, so the battle over water was inevitable. The NGOs volunteers circulated several tablets to them and told them to mix them with their drinking water to combat germs. As a result, refugees used to drink water by combining these medicines. During the rainy season, the roads were slick, so it was very difficult to cross the roads to gather water. Finally, in the rainy season, the water issue has been less excessive due to the fact that they could accumulate rainwater.

V. CONCLUSION

The study illustrated the health and wash situation of the Rohingya refugees in Kutupalong camp 10 & 18. The refugees received free healthcare and medication (mainly primary treatment) from both camps and hospitals. The health care facilities were deficient with the increasing Rohingya population. There were dissatisfactions with access to water and sanitation among the refugees too. The limited number of latrines could not meet the demand of the large population. There numerous injuries were reported for the children and the elderly who had to wait in line of latrine users for inadequate lighting at toilet areas. Shortage of safe water also made their lives miserable. It also caused different waterborne diseases. It can be inferred that the Rohingya refugees had encountered problems leading their lives wretched in camps. On the other hand, the host community perceived that the Rohingya refugees were getting more facilities. Even there were several fracases reported between the host and the refugees' parties Bangladesh's Government, national and several International organizations had been trying devotedly to ensure the minimum standard of living of the Rohingyas. The coordination among the parties involved in Rohingya crisis can lead them a refreshingly life in the camps.

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