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Health and Wellbeing of Conflict and Disaster-Affected Population in Cox's Bazar. Bangladesh

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ABSTRACT: Cox's Bazar, Bangladesh, and northern Rakhine State, Myanmar, are two protracted humanitarian crises that are interconnected. A number of donor interventions are aimed at facilitating community resilience and social cohesion, both within the camps and in the host communities. This study aims to assess the progress and effectiveness of an activity based on an information base and establish benchmarks for impact evaluation. In order to conduct the study, both quantitative and qualitative survey techniques were used. A representative sample size was determined for a quantitative survey, including potential qualitative interview participants. For data collection, we used a structured questionnaire, a semi-structured interview guideline, and an unstructured topic guide. We used mostly descriptive statistics with a few inferential tests for our analysis. The triangulation work was developed with information from both methods to draw a credible conclusion. Based on the results, most of the community's health conditions are improving, which confirms the concept of prevention. In terms of vulnerability indices, the highest majority seemed not as much vulnerable as their family had much aware about the traumatize/stress condition. Pregnant/Lactating Women (PLW) were not pronounced as burden by their families as majority of them made visitation for 4 ANC check-up across the study areas. The knowledge level of prevent communicable diseases were found in optimum level in all study areas. An adequate number of beneficiaries responded that malnutrition was screened and diagnosing properly and referred them in time. Moreover, sufferings from psychological issues were found common in FDMN community. In participants' discussion, It is emphasized that adolescent should be needs of different support and information to cope up with the changes. The study concluded that significant proportion respondents have confirmed about the knowledge of preventive measures, which they learnt mainly from available service provisions. However, it is implied of introducing improve adolescent health services including an adequate supply of necessary of hygiene kits.

KEYWORDS: Primary Health Care, Emergency Relief, Conflict, Disaster, Bangladesh

INTRODUCTION AND BACKGROUND

Globally, 79.5 million people live outside their country of nationality. They are mostly migrants, people who leave their homelands in search of better opportunities. However, over one-third of them are refugees, escaping political violence, and other threats in their own country [1]. The majority of refugees flee to bordering countries, but often with the hope of returning home should situations change. Refugees face a plethora of health problems arising from factors related to their living conditions, which are often overcrowded, with insufficient public utilities or non-existent basic services and social infrastructure [2]. The arrival of refugees is considered as a temporary phenomenon for the host country. The durable solution regarding refugees is that they will be able to return to their homeland voluntarily as soon as the situation, which forced them to flee from their territory, ends [3]. Ensuring human rights and fundamental needs of the Forcibly Displaced Myanmar Nationals (FDMN) has become a critical concern of host and international communities. The Disaster Response Emergency Fund (DREF) is the quickest, most efficient and most transparent way of getting funding directly to local humanitarian actors—both before and immediately after a crisis hits [4].

One of the most concerning phenomena prevailing in Bangladesh is the Rohingya crisis in Cox's Bazar and there are currently 923,179 [5] FDMN living in a mega camp in Cox's Bazar district. They have no refugee status and are referred to as Forcibly Displaced Myanmar Nationals by the Bangladesh government. The Rohingya have been subjected to systematic disenfranchisement, discrimination and targeted persecution in Rakhine State for decades [6]. The majority of the FDMN have become residents in Cox's Bazar district in pre-existing camps and settlements, and amongst the host community in the surrounding areas. As the vulnerable settlement in Cox's Bazar, the opportunities are limited, which eventually significant impacts

on households' purchasing power, food security, especially access to health services. But the focus part of the response operation is continuously undertaken to assist them by various donor organizations through government of Bangladesh. In this connection, the interventions in both camp and host communities are aimed at facilitating community resilience and social cohesion.
Among other supporter organizations, Malteser International (MI) has been providing assistance in northern Rakhine State since 2003 and has been active in Cox's Bazar, Bangladesh since 2017. MI and its partners are long-standing, renowned performers these areas, working primarily in the health sector and then welbing. MI has supported by one of the partner organizations Gonoshasthaya Kendra (GK) in Cox's Bazar, where they work together. In response to the protracted crisis, a joint follow-on project recently scheduled. Thus, this study is needed to gather the benchmark information for implementing the project interventions to improve the health and well-being of a total of thousands vulnerable people affected by the crisis through holistic health and timely emergency response.

For the study references of areas, one camp-1 E situated in Ukhia, Cox's Bazar, Chattogram [7], one camp-11 situated in Cox's Bazar District, Chattogram [8] and another camp-22 situated Teknaf, Cox's Bazar, Chattogram, Bangladesh [9] have been chosen. These three has fully equipped and functional health facilities. Covering these areas, the study aims to measure an information base monitor and assess an activity's progress and effectiveness and establish a benchmark for impact evaluation at the end. The outcomes of this study strengthened the project envisages to improve the health and well-being of vulnerable people affected by the crisis of FDMNs communities.

METHODOLOGY

In order to gather data for key project indicators, the study applied a mixed method combining both quantitative and qualitative survey techniques as well as used secondary data archived in the GK-MI Project database during the study period, which provided a more credible picture of the current status of FDMN communities. The respondents'/participants' categories were considered from the target beneficiaries for the sample selection and those are: (i) Household Member (Adult Male/Female); ii) Pregnant and Lactating Women (PLW); (iii) Person with Disabilities (PWD); (iv) Traumatized/Stress People; (v) Service Providers, Psychologist, Nutritionist, government TBA; (vi) Adolescent boys and Girls; and (vii) Community Influential.

Simple random sampling technique was followed to sampled individuals from FDMN camps and for the household survey. The sample size estimation followed conventional cross section formula followed a maximum adjusted attributed rate with the standard normal distribution reflecting the confidence level of 95% in a finite population, the desired margin of error 5% and the proportion of opts in the population characteristics was unknown. This is estimated 377 sample without considering non-response rate as all the FDMN household staying the own camps with any outside professions. For quantitative survey data was collected from around 370 sample where few sample (7) was not approached due to their untraced condition during survey period. However, the study response rate was 98%. To collect the qualitative data, a number some Focus Group Discussion (FGD) and Key Informant Interview (KII) conveniently conducted across the study areas.

Structured questionnaire was developed and reviewed for different measurements and indices, Semi-structured interview guideline was developed for KII and unstructured topic guide for FGD facilitation was used covering the variables of interest and topics of respondent's context. The instruments were finalized after pre-tested with trained and experienced field personnel and then translated into local language. Quality of data collection was ensued through spot visits of monitoring and minimize the possibility of non- statistical errors. Later, prepared data file used for analysis in adopting mostly descriptive statistics. Data triangulation work was done with quantitative and qualitative outcomes in using the principal means which supported to draw a credible inference.

THE STUDY FINDINGS

The information on respondents' main occupation was not focus in this study due to their current FDMN status where every family continued their livelihood with organizational relief Aids. But can be seen from the following table that some notable proportion of male respondents doing job, making business, pulling rickshaw, fishing (Table-1). On the other, most of the FDMN people are uneducated (average 71%), followed by some of them have received primary education is about 25% and rest of the proportion had secondary and higher education. A highest majority of the respondents are married and mean family size 6.1, which is much higher than that average family size about 4.0 in Bangladesh.

Table 1. Respondents' background profile by FDMN study area (n=370)

Characteristics	FDMN Study Area		
	Camp 1E	Camp 11	Camp 22
Respondents' Occupation			
Service	8.1%	6.7%	3.1%
Small Businesses	1.6%	1.7%	3.9%
Rickshaw Puller/Day Laborer	5.6%	0.8%	0.8%
Agriculture/Fishing	0.8%	0.0%	0.0%
Housewife	59.7%	63.0%	40.2%
Others	2.4%	1.6%	3.2%
Not Applicable (For FDMN)	21.8%	26.0%	48.8%
Total	**124**	**119**	**127**
Respondents' Educational Status			
No education	65.3%	74.8%	73.2%
Primary	29.0%	19.3%	23.6%
Secondary & Higher Secondary	5.6%	5.0%	3.1%
Graduate and above	0.0%	0.8%	0.0
Total	**124**	**119**	**127**
Respondents' Marital Status			
Unmarried	4.8%	7.6%	9.4%
Married	91.1%	86.6%	89.0%
Widow/Widower	4.0%	5.0%	.8%
Divorced/Separated	0.0%	0.8%	0.8%
Total	**124**	**119**	**127**
Mean (± SD) Family Size	5.4 (2.3)	5.6 (2.3)	6.1 (2.4)

It can be seen in the following table (Table-2) that about a highest proportion of the respondents mentioned that they use mobile phones to connect with their friends or relatives across the study areas. Average a little more than 16% of the respondents recognized that they have pregnant women in their houses. However, numbers of lactating mothers has been seen in houses about 33%. Only about 8% families have confirmed that they have PWD persons in their families. Again, the number of stressed/traumatized people among the families is not pronounce in two FDMN camps while in other camp about 30%) people said to have traumatized people.

Table 2. Respondents' Household Vulnerability Indicators in the FDMN Study Area (n=370)

Vulnerability Indicator (Yes response)	FDMN Study Area		
	Camp 1E	Camp 11	Camp 22
Mobile phones in the household	86.3%	86.6%	91.3%
Pregnant mothers in the family	16.9%	17.6%	14.2%
Lactating mothers in the family	36.3%	29.4%	33.1%
Any PWD in the family	5.6%	10.1%	9.4%
Any Stress/traumatized people in the family	8.9%	30.3%	.8%
All (n)	**124**	**119**	**127**

In improvement health and wellbeing of FDMN community, evidence suggests there are different steps we can take to improve people's mental health and wellbeing. Trying these things could help us feel more positive and able to get the most out of life. This research covered some of the aspects in the regards like prevention of health measure, Infant and Young Child Feeding (IYCF), Mental Health and Psychosocial Support (MHPSS), Curative Health Measure, etc.

From the multiple responses, almost 98% people's dwellers in camp 22 have confirmed of having idea about preventive health measures, communicable disease measure, while it is seen about 95% in camp 1E and about 87% in camp 1 (Figure-1).

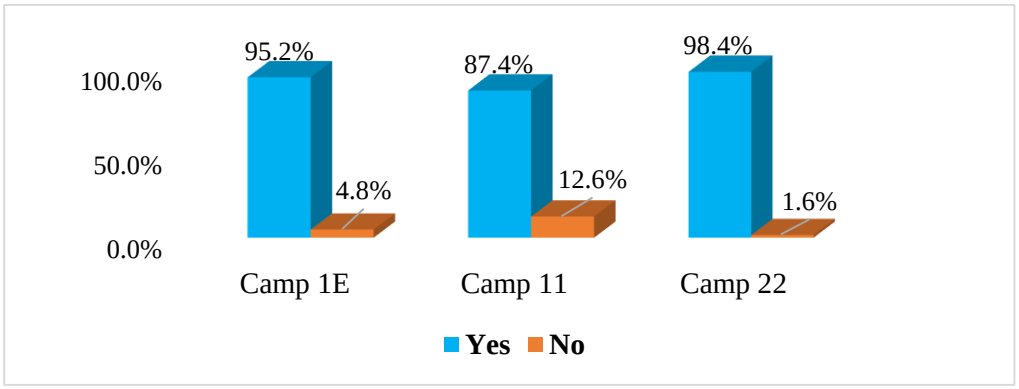

Figure 1. Respondents' knowledge on preventive health measure by study area

Table-3 shows aware on the prevention services by adult male and female, about 96% female are endorsed their awareness on menstrual hygiene across the study area. About 85% female alone in Camp 1E are aware on the measures for their urinary tract or other infections which is seen lower percentage (average 52%) in among the other study areas. The amount of awareness on breast & cervical cancer is seen low compare to other prevention services for the diseases.

Table 3. Awareness on prevention services of diseases among adult female by study area (n=370)

Awareness (Multiple response)	FDMN Study Area		
	Camp 1E	Camp 11	Camp 22
Female Adults, (Base=236)			
Menstrual Hygiene	96.2%	92.0%	98.8%
Urinary Tract/Other infection	84.8%	52.0%	53.7%
Breast & Cervical Cancer	34.2%	18.7%	46.3%
Adult Males, (Base=329)			
Hypertension	65.2%	84.2%	88.5%
Diabetes	77.7%	51.6%	84.4%
STD	50.9%	14.7%	34.4%
Hepatitis B/C	58.0%	38.9%	54.1%
Tuberculosis	50.9%	25.3%	68.9%

On the other hand, about 89% of male in camp 22, followed by 84% in camp 11 and 65% in camp 1E are aware about the services for Hypertension disease. Average 71% of the respondents are aware of diabetic. A good proportion of the respondents are also aware of STD, Hepatitis B/C and Tuberculosis diseases.

Supporting to the above results, group discussion participants, those who leads a group/community in the FDMN camps and leads the Muslim's prayer in the Mosque were confirmed that though there are people with diabetes, hypertension, asthma, pneumonia, dental problems, but the health condition of this area has been improved through awareness after GK clinic started operating.

However, the adolescents were inquired through group discussion on Knowledge on services available at clinics where they supposed to have different supports and information to cope up with their changes but their shared views were not similar to preventives health service provision at GK clinic. In this regard one adolescent quoted an statement that "We seldom visit GK clinic as there remains a huge gathering of people as well as we feel shy to talk to male about our personal things".

To assess the knowledge on preventive health and hygiene measure that practice by the respondents' can be prevented communicable diseases was recorded during interview questions such as Mask Use, Hand Hygiene for COVID-19 & Diarrheal Diseases, Regular Shower for general hygiene & skin diseases, Regular Washing of Clothes, and uses of Mosquito Net for malaria as well as Dengue. All these responses then scored into two categories where those who have the positive knowledge on less than 3 determined questions-answer that categorized as "score-1", i.e., poor knowledge and those who have the positive knowledge on more than 3 determined question-answer that categorized as "score-2", i.e. adequate knowledge in preventing communicable diseases. In Figure-2, a highest majority (average 88%) of people across the camps have been consented towards score-2 about their knowledge of preventing communicable diseases.

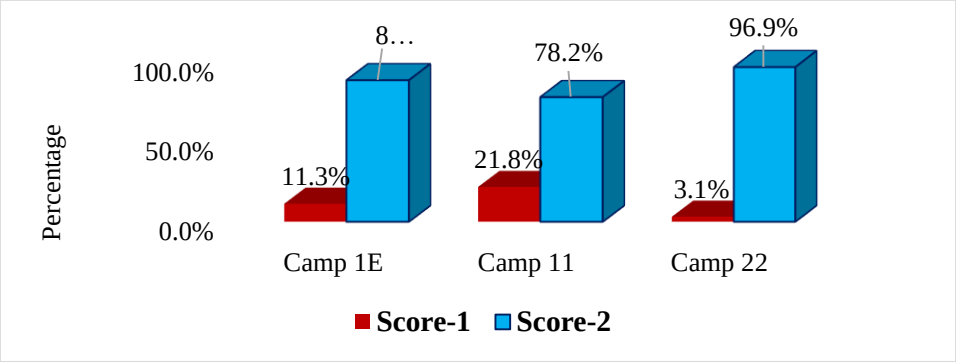

Figure 2. Knowledge Score to Prevent Communicable Disease by FDMN study area (n=370)

Figure-3 is representing the visitation made by pregnant mothers for 4 ANC check-up across the study areas where 65% respondents or women in Camp 11, which Camp 1-E (64%) and Camp 22 (62%) have confirmed about their regular check-up visitations.

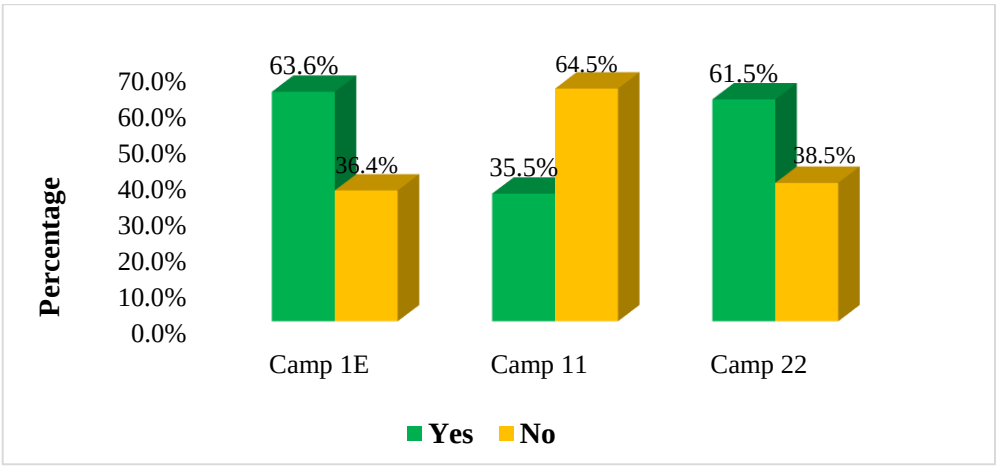

Figure 3. Pregnant Mothers Visited for 4 ANC Check-up by FDMN Study areas (n=370)

When the respondents, especially the lactating mothers were asked whether they have taken the counselling sessions, about 82% in camp 11 have denied of attending such sessions but about 71% in Camp 22 and about 68% in Camp 1E have consented to take such counselling (Figure-4).

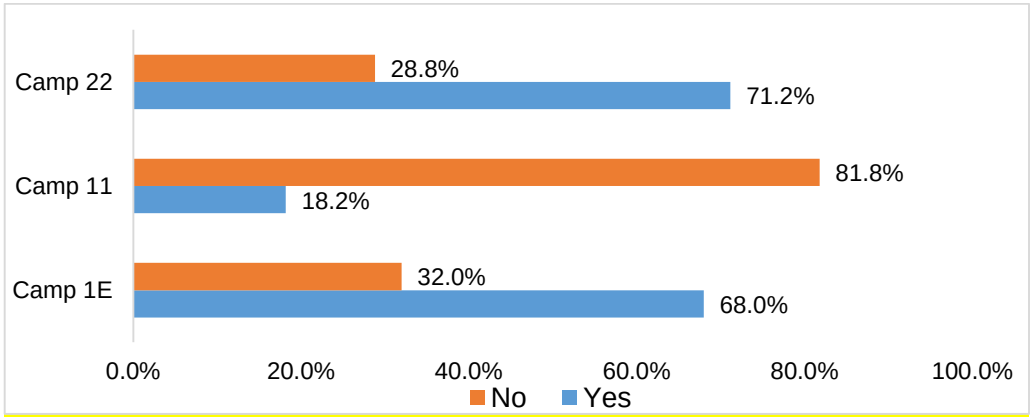

Figure 4. Lactating Mother taken four IYCF counselling sessions after enrollment (n=106)

Mental health and psychosocial support (MHPSS) include any support that people receive to protect or promote their mental health and psychosocial wellbeing. One major component of MHPSS is treatment and prevention of psychiatric disorders such as depression, anxiety and post-traumatic stress disorder (PTSD).

Within the period of Nov'2020 to Oct 2021, a total of 1797 beneficiaries sought psychosocial counselling via individual sessions. Among the total, 486 were male and 1311 were female. The ratio between male and female in such help-seeking

behavior is 1:3 (Figure—5). Again, there was no gender parity documented among these given Psychological First Aid (PFA). About 217 beneficiaries received PFA, among them 102 were male and 115 were female where individual sessions were for the beneficiaries.

On the other hand, clinics in 3 FDMAN Camps have arranged into 187 group sessions on various psychosocial aspects, reaching 1019 participants across the camps. Among the attendees, 146 were male and 873 were female, where only 1 male received such sessions against every 6 women signifying a considerable disparity.

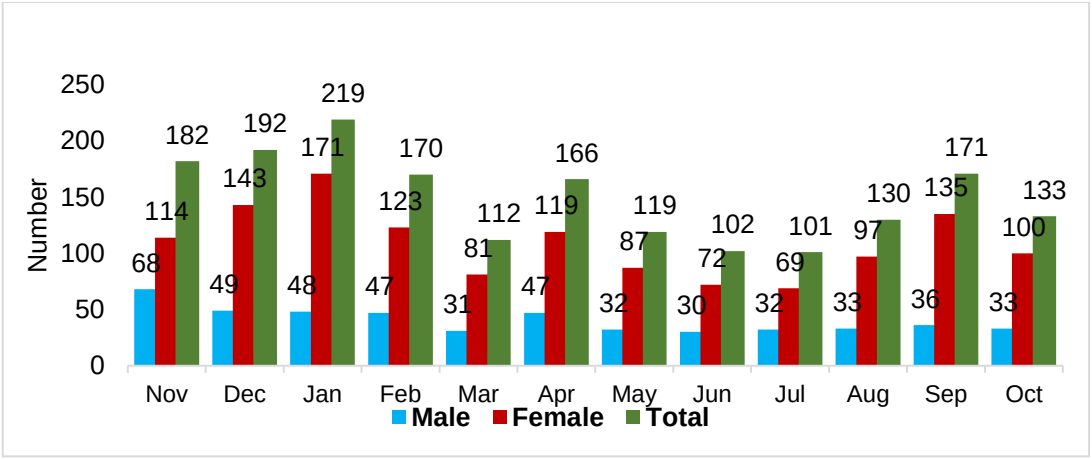

Figure 5. Individual Counselling through MHPSS Camp Areas, Nov'20-Oct'21

Many people in the FDMN community suffer from psychological needs but they are not aware of their psychological illness. In the in-depth interview, a psychologist commented that "After psychological service and sessions people's understanding continues to improve and with psychological support their overall health status improve as well". Females of reproductive age particularly seek services who are mostly affected due to poverty, family conflict, child marriage, spousal (polygamy) and issues with husband's family.

The prevalence of malnourishment among all beneficiaries in the camps will differ as the screening included only under-five children, PLW, and people over sixty years. It's difficult to tell which group has more malnourishment without observing the segregated data. However, in the following figure (Figure-7) shows that both male and female were more or less screened for SAM & MAM over the time period with special screening picked at early or later stage of the same period.

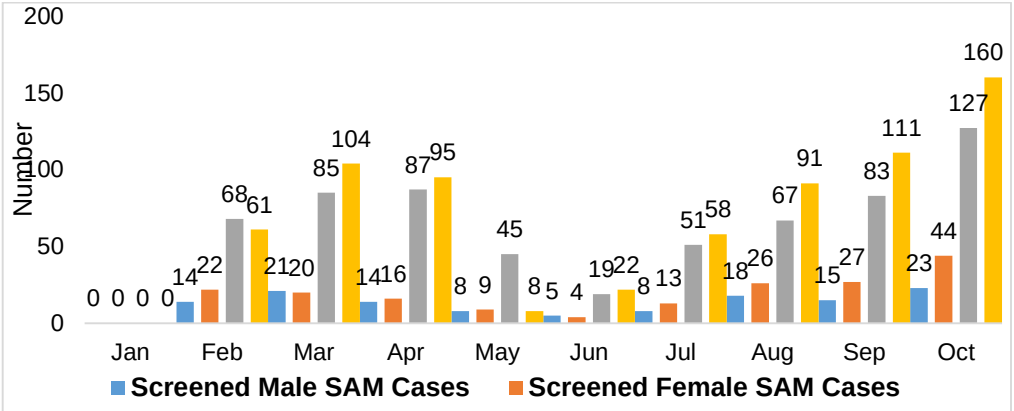

Figure 6. Malnutrition Screening at FDMN Camp Areas, Jan - Oct 2021

As mentioned in the above graph, both male and female were more or less screened for SAM & MAM over the time period with unusual fluctuation. The referral cases of SAM from the 3 FDMN camp's clinics were followed by the same trend fluctuating in different time slots during Jan-Oct 2021 (Figure-not shown).

DISCUSSIONS

The study aims to measure an information base monitor and assess an activity's progress and effectiveness and establish a benchmarks for impact evaluation. The outcomes of this study strengthened the project envisages to improve the health and well-

being of vulnerable people affected by the crisis of FDMN. The study is not limitation due to the COVID-19 pendemic situation where have taken the measure of protection for minimizing of health risk during data collection. This study was consented among sampled people of specific FDMN camps; thus, the results not generalize all FDMN camps at Cox's Bazar in Bangladesh.

The overall response rate of the study is the representation of estimated sample inference with an exception for those sample chosen purposively. Maximum respondents recorded as adult female and male, which is followed by Pregnant and Lactating mothers, national level proportionate of Person with Disabilities and Traumatized/Stress people. In the FDMN camps did not mention any occupation because of their livelihood depends on relief Aids completely. Uneducated respondents were found more across the study areas containing Family Size of 6.1, which is usual size in the FDMN community and not allied to the usual national level family size (about 4.0). The direction of SES outcomes is expected to help improve the intervention design, and program placement modality in focusing FDMN community under the project.

The study results infer that significant proportion of respondents have knowledge of preventive health measures, which they learnt from mainly project's Clinics/Health center. Primary health care (PHC) is the most inclusive, equitable, cost-effective and efficient approach to enhance people's physical and mental health as well as social well-being. It is comparable that PHC in Bangladesh is critical to make health systems more resilient to situations of crisis, more proactive in detecting early signs of epidemics and more prepared to act early in response to surges in demand for services [10]. This tend needs to continue with the required future services. Moreover, the results confirms that FDMN community's health condition continues to improve due to GK-MI project clinics operation with high expectation of clients. A significant proportion of respondents have confirmed about the knowledge of preventive measures, predominantly PLW mothers who were more conscious about these facts, which they learnt from the project Clinics/Health center mainly. In this regard, strengthen of clinic services should focus with further intervention(s). Malnutrition among the sample of Rohingya children in makeshift settlements of Cox's Bazar District, Bangladesh exceeded global emergency thresholds in October–November 2017, shortly after mass displacement from Rakhine State, Myanmar [11]. Along with the maintenance of Emergency and Sexual & Reproductive Health (SRH) referral cases, the project clinics at Cox's Bazar screened adequate number of beneficiaries for malnutrition (MAM & SAM). However, In terms of family vulnerability, with high level of information accessibility, HH population growth is an increasing trend with less burden of disability and stress. Sufferings from psychological issues such as anxiety, depression, sexual disorders, stress, etc. are common in FDMN community, but still people are getting enough understanding even after services/ counselling sessions. It is determined that a high proportion of lactating mothers across the camps have still denied to attending the counselling sessions and screened for malnutrition & its referral followed the steady trend over time. There should be made an effective outreach intervention design for further improvement.

In the group discussion, the adolescents were inquired on knowledge about the services available at FDMN camp's clinic, services received by them and comments on the services. It is merely documented that adolescence is a critical stage of life when girls and boys develop changes in their bodies, minds and choices. It is emphasized that they should be needs of different support and information to cope up with the changes.

Again, the humanitarian situation in Cox's Bazar has been affected by the COVID-19 pandemic and as a result, only critical activities approved by the Refugee Relief and Repatriation Commissioner are possible in the camps. Restrictions, however, have impacted the distribution process and hindered the regular Post Distribution Monitoring (PDM) [12]. The study result revealed that in the event of a disaster or displacement of people due to conflict, relief items are distributed within efficient and effective time. Additionally, there are both internal and external committees in the Project office and in the field level with required budget allocation. However, there should be a rigorous strategic planning with partners in the long-term basis.

CONCLUSIONS

The study gathered benchmark information with the overall maximum response rate inference to beneficiary's population in an expected direction. The study concluded that significant proportion of surveyed respondents have confirmed about the knowledge of preventive measures, which they learnt from GK-MI project Clinics/Health centers mainly. This knowledge found more prevailing among pregnant and lactating mother as well as reproductive women.

The study also concludes that the knowledge level of preventive measure towards communicable diseases like Mask Use and hand hygiene, regular shower & wash cloths, use mosquitoes net, etc. were high across the study areas. Data confirmed that majority of pregnant mothers made visitation for 4 ANC check-up. While there are some women who had not perform such visits due to distance service point, family barriers and their poor interest towards the sessions.

The study results determined that screening of malnutrition index with proper referral system routinely performed but a steady trend over the project periods noticed. Furthermore, the study confirmed that in the event of a disaster or displacement

of people, relief items will be distributed within government approval/cluster coordination planning. However, internal committees in Cox's Bazar Project office required budget allocation for prospective emergency response.

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