

Health Status of 20,769 Rohingya Refugees in Cox's Bazar Refugee Camp, Bangladesh

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Received: 04 October 2023 / Accepted: 06 November 2023

ABSTRAK

Kajian ini bertujuan untuk melihat isu kesihatan primer di dua kem pelarian di Cox's Bazar iaitu di Kutupalong dan di Balukhali. Perbandingan kes-kes penyakit dijalankan antara kumpulan umur dan jantina yang berbeza. Data mengenai isu kesihatan primer, rujukan, perkhidmatan ibu dan anak serta perkhidmatan perancangan keluarga dikumpul dari November 2017 sehingga Mei 2018. Dari 20,769 pelarian Rohingya, 38.2% (7,935) adalah lelaki dan 61.8% (12,834) adalah perempuan. Dari kesemua pelarian, 28.1% (5,831) adalah kanak-kanak yang kurang dari 5 tahun dan 71.9% (14,938) berumur 5 tahun dan ke atas. Semasa kajian, 45.5% (9,441) pelarian mengunjungi klinik di Balukhali dan 54.5% (11,328) mengunjungi klinik di Kutupalong. Hasil kajian menunjukkan 48% kunjungan rawatan kesihatan adalah disebabkan penyakit berjangkit dan 52% bukan penyakit berjangkit. Masalah kesihatan primer yang tertinggi adalah jangkitan pernafasan akut (29.3%) diikuti cirit-birit (9.2%), masalah kulit (4.6%), luka-luka serta kecederaan (2.0%) dan demam yang tidak dikenalpasti (1.4%). Dari segi penyakit berjangkit, terdapat perbezaan signifikan ($p < 0.001$) di antara kanak-kanak yang berumur kurang dari 5 tahun (71.7%) dan mereka yang berumur 5 tahun dan ke atas termasuk orang dewasa (38.6%). Oleh itu, bagi penyakit berjangkit, kami mengesyorkan program kesedaran kesihatan yang kerap supaya dapat mengurangkan dan mengelakkan daripada wabak penyakit. Untuk penyakit tidak berjangkit, rawatan dan pemantauan kerap hendaklah dilakukan. Penambahbaikan kesihatan dan status sosial pelarian pasti memberi faedah kepada negara tuan rumah pelarian.

Kata kunci: Kem pelarian; kesihatan awam; pelarian

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ABSTRACT

We aimed to assess the burden of primary health issues in two refugee camps in Cox's Bazar. We compared the burden of disease between different age groups and gender. Data on primary health issues, referrals, maternal and child services, and family planning services were collected from November 2017 to May 2018. The sample population was 20,769 Rohingya refugees who had sought medical care; 38.2% (7,935) were males and 61.8% (12,834) were females. Those younger than five years of age constituted 28.1% (5,831), and those five years old and older constituted 71.9% (14,938). The findings revealed that 48% of the sample population sought medical care due to infectious diseases. Acute respiratory infection (29.3%) was the most frequent primary health problem encountered by refugees, followed by diarrhea (9.2%), skin problems (4.6%), injuries/wounds (2.0%) and unexplained fever causes (1.4%). There was a significant difference in the infection rate ($p < 0.001$) between those younger than five years of age (71.7%) and those five years of age or older (38.6%). For communicable diseases, we recommended regular health awareness programs to reduce and prevent outbreaks. For noncommunicable diseases (NCDs), regular treatment and monitoring were essential. Improving the health and social status of refugees will definitely benefit the host country.

Keywords: Public health; refugees; refugee camp

INTRODUCTION

The Rohingya plight continues to be a politically sensitive issue. Following escalation of ethnic violence in Myanmar's Rakhine State on August 25, 2017, over 500,000 Rohingya refugees crossed into neighboring Bangladesh in less than five weeks. The United Nations described this situation as the "world's fastest growing refugee crisis" (Edwards 2016).

In view of that, the Medical Relief Society (MERCY) of Malaysia, a nonprofit national organisation offers medical and emergency assistance to vulnerable communities, acts by deploying to Cox's Bazar, Bangladesh, to assist in the humanitarian crisis.

This paper focused on refugees from Myanmar identified as Rohingya. The Kutupalong and Balukhali areas were the two focus areas of our research in Cox's Bazar refugee settlement.

We aimed to (i) compare the burden of disease between different age groups, and (ii) compare the burden of disease between different genders. A systematic review conducted in 2020 of 12 articles and 21 organisational reports found major health problems of unexplained fever, acute respiratory infection and diarrhoea (Joarder et al. 2020). Our study provides further depth over a period of 6 months adding further useful data on refugee health to develop targeted interventions for primary health issues.

MATERIALS AND METHODS

The field research for this study was conducted in the Kutupalong and Balukhali areas of the Kutupalong refugee settlement near Cox's Bazar, Bangladesh, from November 2017 to May 2018. The target group comprised all Rohingya refugees regardless of age and gender who sought medical care in the clinics of MERCY Malaysia in either the Kutupalong or Balukhali area. Related data on primary health issues, referrals, maternal and child services, and family planning services were collected from the patient medical records of MERCY Malaysia's two clinics. Ethical committee approval was obtained with a code number of UKM-JEP-2021-511 from the collaborating university. The inclusion criteria were that they must be Rohingya refugees, reside in either the Kutupalong or Balukhali area of the settlement, and visit the health clinic administered by MERCY Malaysia. A total of 20,769 refugees, comprising 7,935 males and 12,834 females, participated in the study.

This research utilised a cross-sectional study design and employed both qualitative and quantitative methods. Related information on sociodemographic characteristics, primary health issues, referrals, maternal and child services, and family planning services were collected. Each patient was recorded once to avoid duplication of recorded data.

RESULTS

Of the 20,769 Rohingya refugees, 38.2% (7,935) were males and 61.8% (12,834) were females. There were 28.1% (5,831) younger than five years old and 71.9% (14,938) five years old or older. During the study period, 45.5% (9,441) of the refugees visited the Balukhali clinic and 54.5% (11,328) visited the Kutupalong clinic (Table 1).

The data showed that 48% sought medical treatment due to infectious diseases and 52% due to noninfectious or noncommunicable diseases. For infectious diseases, the most common type was respiratory infection (61.0%), followed by gastrointestinal

TABLE 1: Demographics of patients treated in the Kutupalong and Balukhali clinics near Cox's Bazar

Clinic Attendance According to Site, Gender and Age Group			
	Balukhali Clinic	Kutupalong Clinic	Total
Gender	n	n	
Males	3174 (33.6%)	4761 (42.0%)	7935 (38.2%)
Females	6267 (66.4%)	6567 (58.0%)	12834 (61.8%)
Total	9441	11328	20769
Age Group			
< 5 years old	2993 (31.7%)	2838 (25.1%)	5831 (28.1%)
5 years old and above	6448 (68.3%)	8490 (74.9%)	14938 (71.9%)
Total	9441	11328	20769

(19.26%), dermatological (9.61%), hematological (4.21%), mixed (4.12%), ophthalmological (1.77%), and neurological (0.03%) (Figure 1).

We categorised data into 16 groups of diagnoses together with a “other or miscellaneous” category (Table 2). Acute respiratory infections (29.3%) produced the highest percentage of primary health problems encountered,

followed by diarrhea (9.18%), skin problems (4.62%), injuries or wounds (1.98%), unexplained fever cases (1.45%) and others (51.86%). The other diagnoses were less than 1% (Table 2). The details were shown in Table 2 and Figure 2.

Graphs of the primary health issues by age and gender were as follows: by age group, Figure 3 was for younger

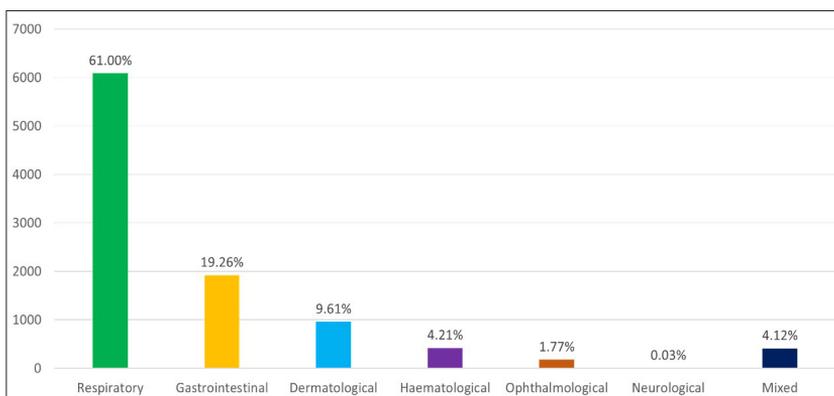


FIGURE 1: Disease types according to systems in the body of the Kutupalong and Balukhali clinic patients near Cox’s Bazar

TABLE 2: Classification of health problems according to diagnoses together with number of patients and percentages in both Kutupalong and Balukhali clinics

Primary health issues	n	%
Acute Respiratory Infection	6085	29.3
Diarrhoea* (<i>see breakdown below</i>)	1905*	9.18*
Skin Problems	959	4.62
Injuries / Wounds	411	1.98
Unexplained Fever	301	1.45
Eye Problems	177	0.85
Suspected Mumps	102	0.49
Severe Malnutrition	22	0.11
Acute Jaundice Syndrome	16	0.08
Suspected Malaria	11	0.05
Suspected Measles / Rubella	5	0.02
Suspected Meningitis	3	0.01
Suspected Haemorrhagic Fever	1	0
Others	10771	51.86
TOTAL	20769	100
*Breakdown of diarrhoea cases		
Acute watery diarrhoea	805	3.88
Bloody Diarrhoea	178	0.86
Other Diarrhoea	922	4.44

than five years old, and Figure 4 was for five years old and older; by gender, Figure 5 was for males, and Figure 6 was for females.

Additional data were available from March 2018 to May 2018. These pertained to the following: (i) Urgent and nonurgent referrals: A total of

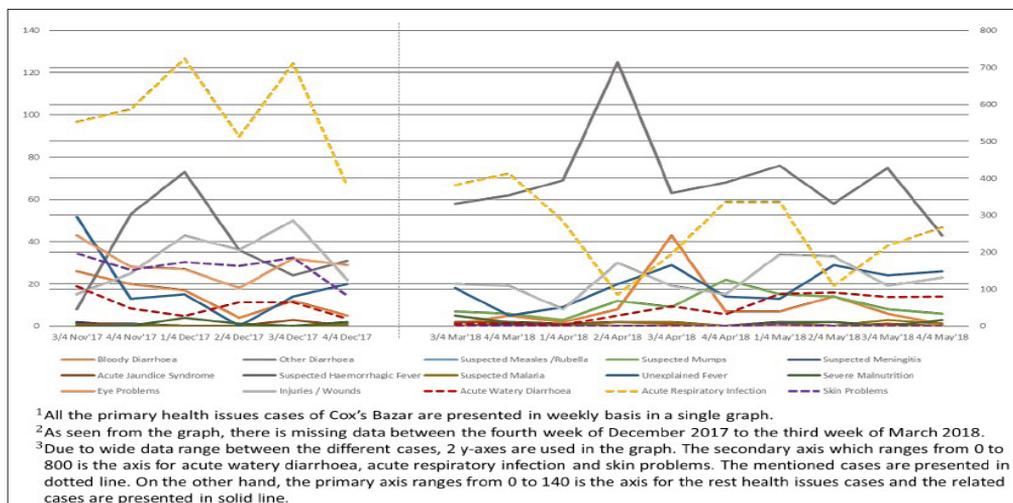


FIGURE 2: Trends of primary health issues of the Kutupalong and Balukhali clinic patients near Cox's Bazar measured weekly. Note missing data from the fourth week of December 2017 to the third week of March 2018. Due to the wide range of cases, two y-axes were utilised. The second y-axis on the right ranged from 0 to 800 for acute watery diarrhoea, acute respiratory infection, and skin problems. The y-axis on the left ranged from 0 to 140 for all other health issues

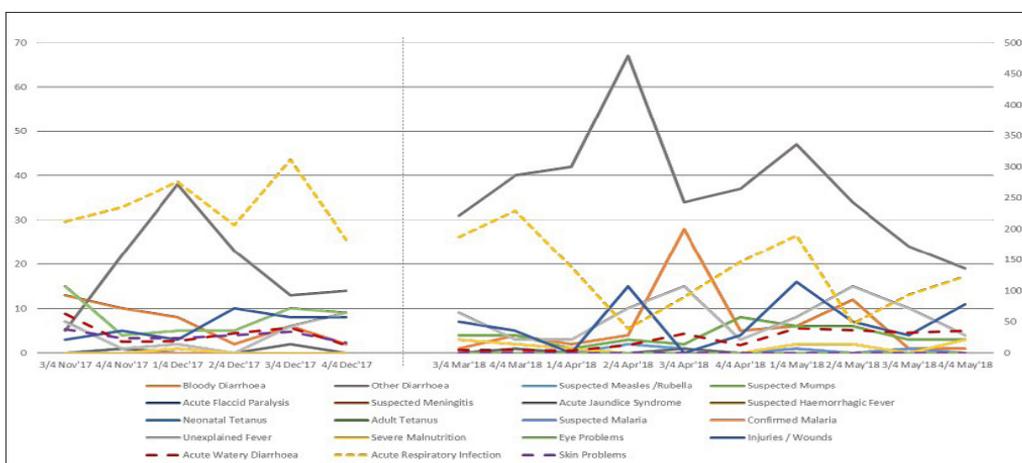


FIGURE 3: Trends of primary health issues in children younger than five years old from the Kutupalong and Balukhali clinic patients near Cox's Bazar. Note missing data from the fourth week of December 2017 to the third week of March 2018. Due to the wide range of cases, two y-axes were utilised. The second y-axis on the right ranged from 0 to 800 for acute watery diarrhoea, acute respiratory infection, and skin problems. The y-axis on the left ranged from 0 to 140 for all other health issues

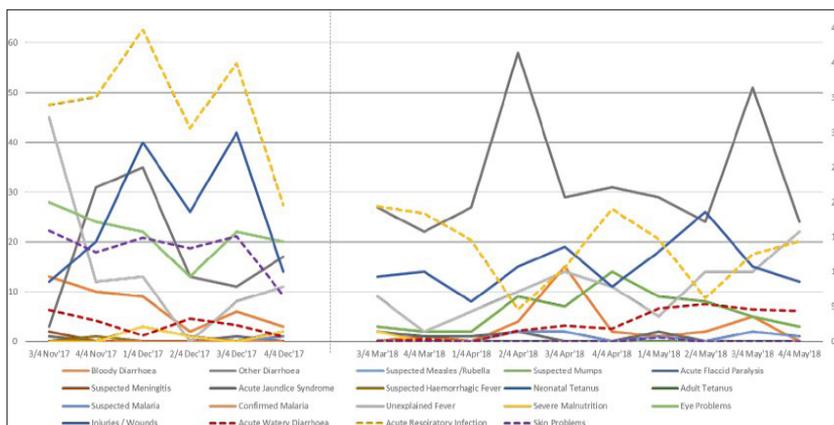


FIGURE 4: Trends of primary health issues in those five years and older from the Kutupalong and Balukhali clinic patients near Cox’s Bazar. Note missing data from the fourth week of December 2017 to the third week of March 2018. Due to the wide range of cases, two y-axes were utilised. The second y-axis on the right ranged from 0 to 800 for acute watery diarrhea, acute respiratory infection, and skin problems. The y-axis on the left ranged from 0 to 140 for all other health issues

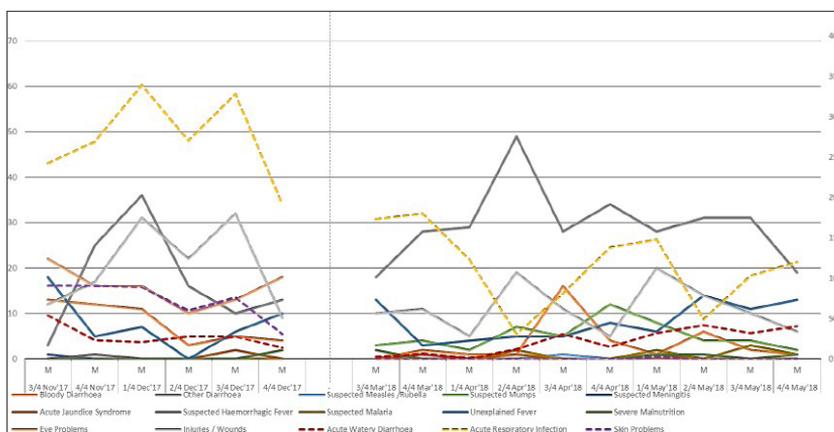


FIGURE 5: Trends of primary health issues in the male population from the Kutupalong and Balukhali clinic patients near Cox’s Bazar. Note missing data from the fourth week of December 2017 to the third week of March 2018. Due to the wide range of cases, two y-axes were utilised. The second y-axis on the right ranged from 0 to 800 for acute watery diarrhea, acute respiratory infection, and skin problems. The y-axis on the left ranged from 0 to 140 for all other health issues

382 referrals were made, with 2.4% (9 cases) urgent referrals and 97.6% (373 cases) nonurgent; (ii) Maternal and child services: A total of 391 refugees sought this service, comprising 93.4% for antenatal care and 6.6% postnatal care. There were no deliveries; (iii) Family planning service: A total of

65 refugees sought this service and were treated with a combined oral contraceptive pill (36.9%), depot medroxyprogesterone acetate (DMPA) injection (35.4%), progesterone-only pill (23.1%) or condom (4.6%). No emergency pill treatment was given.

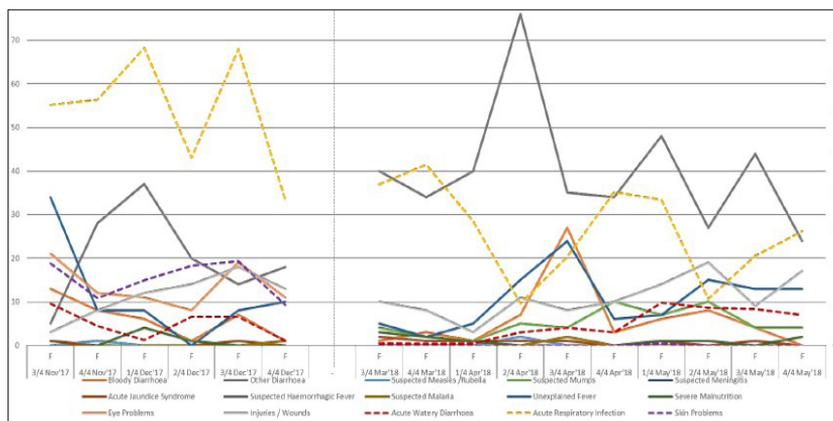


FIGURE 6: Trends of primary health issues in the female population from the Kutupalong and Balukhali clinic patients near Cox's Bazar. Note missing data from the fourth week of December 2017 to the third week of March 2018. Due to the wide range of cases, two y-axes were utilised. The second y-axis on the right ranged from 0 to 800 for acute watery diarrhoea, acute respiratory infection, and skin problems. The y-axis on the left ranged from 0 to 140 for all other health issues

DISCUSSION

Across all diseases, males were more likely than females to present with a disease, but this could be due to males were more likely to be allowed outdoors and had access to healthcare. The prevalence of noninfectious diseases (52%) was higher compared to infectious diseases (48%). The most frequent health problems encountered were chronic medical conditions or noncommunicable diseases (NCD). Chronic diseases, such as hypertension and diabetes, were perceived to be common among Rohingya refugees, especially the elderly; however, we did not have data in this area.

The prevalence rates of infection vary between studies and have not been studied comprehensively using representative samples (Clarke & Mytton 2007). Rohingya refugees live in overcrowded spaces, escalating the risk of potential outbreaks of

communicable diseases. Data from December 2017 showed that the Kutupalong refugee settlement and the Kutupalong makeshift camp had space per person of 17.15 and 7.78 square meters, respectively, whereas the Balukhali makeshift settlement had space per person of 4.47 square meters (Cai & Scarr 2017). These figures are far below the guidelines set by the United Nations for the density of a refugee settlement, which is 35 square meters per person; the overcrowding in these areas is extremely serious (Cai & Scarr 2017).

Transmission of infectious diseases is linked to both human mobility and susceptibility to infection. Infectious diseases easily spread through movement of people, animals, and goods, and the spread is exacerbated by overcrowding (Abbas et al. 2018). Children younger than five years old are more susceptible to infection, as reported by our data. The sample

population younger than five years had a significantly ($p<0.05$) higher rate of infection (71.7%) compared to those five years and older (38.6%). This could be due to an immature immune system and low vaccination coverage of those younger than five years old as a result of limited access to healthcare in Myanmar. Vaccine-preventable diseases can be reduced through vaccination campaigns for Rohingya refugees.

For acute respiratory infection (ARI), the total number of cases seen in camp was 6,085 (29.3%) cases, which was the highest number of any primary health issue among the refugees. Our data was similar to a report that ARI was the number one killer in refugee settlements (Ahmed et al. 2012). Also, ARI had remained the primary cause of mortality for the settlement population living in Cox's Bazar (28%) and for children under five years old (38%). Interestingly, in MERCY Malaysia's outpatient field hospital after typhoon Haiyan in the Philippines, there was a much higher presentation of ARI, 73.1% of consultations, of which 83% were children (Gil Cruستا et al 2020).

Children younger than five years old had a significantly ($p<0.001$) higher rate of infection (46.4%) compared to those five years old or older (22.6%), and it was more than twice as high as for those five years old or older, suggesting more disease burden and severity in this group. Again, an immature immune system and low or incomplete vaccination status of those younger than five years old could be a factor.

There was a significant difference

in the ARI rate between males and females. Male refugees had a significantly ($p<0.001$) higher rate of infection (35.1%) compared to females (25.7%). Possible reasons were that males were usually tasked to do outside work, such as repairing or building camps and looking for food and other resources. They were much more likely to be in contact with other people than females, who were mostly confined to their shelters or homes.

There was a total of 1,905 cases of diarrhea recorded, 805 (42.3%) of acute watery diarrhea, 178 (9.3%) of bloody diarrhea, and 922 (48.4%) of other diarrhea. Due to the limited access to the communal latrines and the great distance of the latrines from some households, some chose not to use them (Cai & Scarr 2017). Conversely, some households were too close to latrines. This undoubtedly contaminated the sources of water and food and posed extremely high health risks.

In 2017, over 86% of water samples in Kutupalong and Balukhali refugee camps showed an unsurprising growth of *Escherichia coli*, which is an indicator of fecal contamination. There was a significant difference in total diarrhea rates between Balukhali and Kutupalong. Refugees in Balukhali had a significantly ($p<0.001$) higher rate of infection (17.1%) compared to those in Kutupalong (6.1%). Since diarrhea can be spread through feces, the number of people sharing latrines was analysed. According to data by the United Nation (UN) migration agency IOM, the ISCG coordinating body, and the disaster assessment agency REACH,

the average number of people sharing a latrine in Balukhali camp was 115, which was much higher than in other zones, such as the Kutupalong camp (Cai & Scarr 2017). Again, the numbers were far higher than the guidelines set by the UN, which only allow 20 people per latrine (Cai & Scarr 2017).

There were no significant differences in acute watery diarrhea rates between the camps, whereas both bloody diarrhea and other diarrhea showed significant differences. Children younger than five years had a significantly ($p<0.001$) higher rate of infection (17.1%) compared to those five years old or older (6.1%). All three types of diarrheas demonstrated significant differences between the age groups ($p<0.001$), with those younger than five years old exhibiting higher rates of diarrhea. Our data aligned with a report mentioning that diarrhea-related diseases were the second highest contributor to the death of children younger than five years old (Banerjee 2019). Due to immature immune systems, those younger than five years old are especially susceptible to diarrhea caused by poor living conditions, and their susceptibility is exacerbated by poor nutrition.

Males had a significantly ($p<0.001$) higher rate of infection (10.8%) compared to females (8.1%). All three types of diarrhea demonstrated significant ($p<0.001$ for acute watery and other diarrheas and $p<0.05$ for bloody diarrhea) differences between males and females, with higher rates in males. Again, a possible reason was that males were more likely to be outside consuming non-home-cooked

food in unhygienic roadside stalls.

Overall, there were 102 cases of suspected mumps. Children younger than five years of age had a significantly ($p<0.05$) higher rate (0.7%) of suspected mumps compared to those five years old or older (0.4%). Males had a significantly ($p<0.05$) higher rate (0.6%) of suspected mumps compared to females (0.4%). This aligned with the study of a large mumps outbreak in Palestinian refugee camps, which showed a male-to-female ratio of 1.3:1 (Hindiye et al. 2019).

There were less than 1% of cases of suspected meningitis, acute jaundice syndrome, suspected hemorrhagic fever, eye problems, suspected malaria and unexplained Fever / Pyrexia with no major significance difference in age group or gender in these diseases. There were 959 cases of skin problems. Skin problems include fungal infection and scabies due to lack of access to clean water, poor living conditions, and overcrowding. More than 65% of skin problems were due to communicable diseases (bacterial, viral, and mycotic) and scabies (Wollina et al. 2016). In a Cambodian refugee camp, skin infections were the second most common problem encountered after acute respiratory syndrome for children and after prolonged fever for adults (Elias et al. 1990).

Children younger than five years of age had a significantly lower rate (2.8%) of skin problems compared to those five years old or older (5.3%). Again, males had a significantly ($p<0.001$) higher rate (5.6%) of skin problems compared to females (4.0%). One factor was their more frequent

outdoor activities. Males were also more likely to have a lower awareness of hygiene. The simple practice of washing hands, clean water, and well-maintained sanitation facilities would help to reduce and prevent many skin conditions.

There were 411 cases of injuries or wounds. Males had a significantly ($p < 0.001$) higher rate (2.9%) of injuries or wounds compared to females (1.4%). Males were more likely to be injured or assaulted in their home villages while protecting their families. Bangladeshi authorities had treated more than 2,350 Rohingya refugees for serious injuries sustained from ethnic violence in Myanmar, including bullets, mines, or sharp weapons like knives (The Straits Times 2017). Additionally, males are involved in more outdoor activities to gain necessities. Due to increased male engagement activities, some are involved in conflicts or violence within the camp. Newly reported male sexual and gender-based violence (SGBV) cases in the camp, as recorded in the UNHCR internal database, rose from 1% to 7% from January to May 2018 (Womens Refugee Commission 2018). Otherwise, there was no significant difference in the rate of injuries or wounds for different locations and age groups.

No babies were delivered because most women chose not to give birth in clinics or hospitals as they usually deliver at home, attended by the traditional birth attendants, just as they did in Myanmar. Refugees usually lack health-seeking knowledge, and this may explain the low number of cases of postnatal care. Awareness of

available health care services has to be instilled in the refugees so that those in need are ready to adapt to the services. Language is a further barrier that keeps refugees from understanding and seeking the healthcare system of the host country as well as communicating effectively with healthcare providers.

Our collected data showed that only 65 refugees sought family planning service within the two months. The approximate population of Cox's Bazar was 900,000, so this service was extremely underused by the refugees. Both contraceptive pills (combined oral contraceptive pill and progesterone-only contraceptive pill) were the most frequent method used due to their accessibility.

Half of the data (51.86% or 10,771 cases) did not fall into any of the 15 categories of diseases and were classified as "others." The present study had several limitations. There was a two-month absence of data in January and February of 2017 as data collected was insufficient due to the dynamic field situation. We were not able to discern if the consultations were repeat consultations with language barrier as a difficult issue. We were not able to document follow-up visits and were thus prevented from monitoring and evaluating patient progress and management.

CONCLUSION

The most prevalent primary health issue was acute respiratory infection followed by diarrhea and skin problems. Males had a higher likelihood of having a disease. Children younger

than five years of age had a higher risk of contracting an infection. Regular health awareness programs can prevent outbreaks of communicable diseases, especially vaccine-preventable diseases together with managing non-communicable diseases. A holistic and multidisciplinary approach addressing refugee health and social status will definitely benefit the host country.

CONFLICT OF INTEREST

The authors declared no form of financial support relating to the submission, including pharmaceutical company support, and no commercial or financial involvements.

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