

Mental Health Condition of the Children in Humanitarian Crisis: A Study in Rohingya Kutupalong Camp

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Abstract

In August 2017, the Rohingya genocide erupted into a global refugee crisis, as a large number of Rohingya refugees fled Myanmar for Bangladesh. This global public health epidemic carries a significant mental health impact. Myanmar's combat situation, trauma, as well as post-migration situations such as resettlement camp environments, could lead to serious mental health issues. The purpose of this study was to learn more about the children's experience in Myanmar from Bangladesh's Kutupalong refugee camp in Cox's Bazar, as well as their present mental health situation. The research was designed as a qualitative study, and 13 children were chosen as participants. The study was completed in 2018. The information gathered was transcribed, triangulated, and thematically analysed. Post-traumatic stress disorder (PTSD), anxiety, depression, and somatic symptoms were all cited by the majority of respondents. They frequently suffered from flashbacks, nightmares, panic attacks, suicidal ideation, trauma, palpitation, sleep disturbances, and physical aches for no apparent reason. Because of the time restrictions, this study was able to produce concise results. This research could aid in understanding potential mental health interventions for Rohingya refugee children.

Keywords: Mental Health, Rohingya Children, Depression, Anxiety, PTSD

List of Abbreviations

PTSD - Post-Traumatic Stress Disorder
ISCG - Inter Sector Coordination Group
NGOs - Nongovernmental Organisations
WHO - World Health Organization's
TLCs - Temporary Learning Centres

1. Introduction

The flight of the Rohingya people from Myanmar to Bangladesh has been one of the most catastrophic refugee crises in recent years. Almost a million Rohingya Muslims migrated to Bangladesh's Cox's Bazar in August 2017 to escape destruction, chaos, and brutality in Myanmar [1]. They were the subject of suspicion by the Rakhine Buddhist Community and the National military government [2]. They were displaced from their birthplace and are now seeking sanctuary in Bangladesh, where over half of the population (nearly 55 percent) is made up of children who were experiencing various forms of psychological trauma and hardships due to violation of human rights, burning their family properties, family execution, and sexual violation [2-5]. It was a strain on the Bangladeshi host community, which is already suffering from underdevelopment in Cox's Bazar [6].

With the assistance of the Bangladesh government, various national and international nongovernmental organisations (NGOs) offered health care to this additional population [6]. More than 100 basic healthcare units, 33 primary healthcare units, and 10 secondary healthcare units are managed by these organisations [6]. However, in the midst of the Rohingya humanitarian crisis, these facilities are struggling to provide adequate mental health and psychosocial support. Location, language barriers, uncoordinated mental health services and management, and a misunderstanding of mental health and its services make it difficult to provide services to the appropriate person [6]. Furthermore, the Rohingya people are more susceptible to mental health illnesses like as depression, anxiety, trauma, and stress due to exposure to several variables such as the camp environment, isolation from family and friends, abuse, financial restrictions, and uncertainty about the future [7].

The Myanmar military has terrorized children, and they are the most afflicted group. More than 22 percent of the total population is considered to have mental health difficulties [8]. It appears that these children will be approaching adulthood in the camps. Physical and sexual assault, as well as mental trauma, made children the most vulnerable members of society. According to a study, despite the fact that 30.4 percent of Rohingya children suffer from mental problems such as PTSD, anxiety (26.8%), and grief (21.4 percent), just one percent of the children receive mental health services during the humanitarian crisis [8].

Several sorts of health risks produced by the camp environment, as well as living with traumatic events, can lead to severe stress and other mental illnesses, which can have a negative impact on the quality and development of children's life. Physical and psychological abuse, family distress, a harsh environment, and negligence when under the age of 18 have all been associated with lasting impairments in children's physical, emotional, and social development [9]. The purpose of this study is to investigate the experiences in Myanmar and the mental health conditions of Rohingya children in the Kutupalong campsite in Cox's Bazar, Bangladesh, and to characterize the facts using theme analysis from the perspective of the children.

2. Methodology

2.1. Study Design and Study Site

The current study was conducted on refugee children in Bangladesh's Rohingya Kutupalong camp. Only qualitative data on mental health was observed for the current investigation. The research was completed in January 2018. The participants were chosen using a procedure known as purposive sampling.

2.2. Participants and Procedure

While reviewing the literature and observing the children of the camp, children seemed to display severe vulnerabilities which was the reason to be selected as a participant for the present investigation. A total of 11 children's parents agreed and consented to engage in the researcher's in-depth interviews (IDIs).

The children were invited to express their experiences of trauma and violence while fleeing Myanmar, as well as their current mental circumstances in the camp, in an open-ended guideline relevant to the study. To ensure application in the field, the open-ended guideline was created based on literature reviews and field data. Because the children were wary of strangers and the mothers could comprehend and feel at ease with the researcher, the mothers were the interviews for the children under the age of ten. Children over the age of ten were interviewed with their consent and in a comfortable environment to ensure compliance.

2.3. Data Collection

The IDIs were conducted face-to-face in the children's homes for qualitative data because it was more convenient and comfortable for them to participate. The guideline was pre-tested and further developed based on the findings of the children who were not sampled. The interviews lasted about 35-40 minutes.

2.4 Data Analysis

All of the interviews were conducted in Chittagongian and electronically recorded. They were then directly transcribed into Bengali and then English and later, thematic analyzed, which provided a more detailed explanation of the data and themes. The information was coded and extracted for each theme. The themes were finalised under the influence of "The World Health Organisation's International Classification of Disease (10th Edition)" known as ICD-10. The findings of different participants were compared and contrasted to achieve triangulation. The accuracy of the transcribed data was reviewed, and the theme and sub-theme were finalized.

3. Results

3.1. Demographic Information

The participants ranged in age from eight to fourteen years old. Six male and five female children took part in the study. The participants were mostly from low-income homes. The participant children and under 10-years-old children's mothers were interviewed at home. Due to budgetary constraints at the time of the investigation, the mothers and children had no official education in Myanmar, and the children were not attending any school setting organized by NGOs.

3.2. Before the Relocation, Life at Home

The participants in the current study's examination initially explained their circumstances in Myanmar, where they were not living as refugees. They were living hand to mouth in Myanmar, with everyone in the family present.

"My father worked as a day laborer and my mother was a homemaker. Because my father's earnings were insufficient, my other brothers stepped in to help him. Because he was a toddler, only my youngest brother was left."— A 13 years old female participant

"We lost his father to the sickness a few years ago," a mother of an eight-year-old male participant told the researcher. *"His older siblings are now contributing in the family's survival. But I'm concerned about him not having a father in the household."* Another participant, a 14-year-old girl, stated,

"As the Myanmar army began their homicidal onslaught, we hid in fear at home. We had stopped working on the field and were having difficulties. My father was straining to provide for his family's basic needs."

Despite the fact that most of the children's families struggled to keep their families together in Myanmar, they had come to terms with their financial constraints. Overnight, their hard but peaceful lives were turned upside down. The majority of the families were targeted at night.

"One night, the Myanmar army, consisting of 13-15 soldiers, broke into our home. My parents were shot in front of my eyes, and my brothers were similarly slain one by one." - a 14-year-old female contestant

The majority of the participants had witnessed home invasions, soldiers abusing neighbors and family members, and people being murdered, as well as the death of a family member and arson.

"The Myanmar army arrived one day and began torturing our family and neighbors," a mother of nine-year-old male child claimed. "As a result, we started running. A man stabbed my child in the shoulder with a large knife while we were driving. When he dropped to the ground, he was dripping with blood. Due to considerable bleeding, he was rendered unconscious and has no recall of how he arrived at a new location."

"One night we lost our home, the neighbors and others who were killed in the genocidal attack because it happened so quickly. He has seen so many wounded and exhibited dead bodies on the route to Bangladesh that he is having too much difficulty dealing with reality." A mother of nine years old male participants. The situation for women in the Rohingya community was significantly worse. Some were raped, assaulted, and tortured.

"After the soldiers slaughtered my family, they raped me," two of the female volunteers over the age of 12 said. "Despite my appeals for help and forgiveness, they tortured me. In a gang, they raped me. I remained awake until the third person spoke. I went unconscious after that. After that, I have no recollection of what happened."

"I went outside to pick some vegetables one day, and the soldiers came upon me on the road. They kidnapped me and assaulted me sexually. I was a gang rape victim. I felt so ashamed and afraid that I couldn't tell my family because I was afraid they would reject me. They're going to abandon me permanently."

Their mental health status was discovered to be worrying as a result of their experiences in Myanmar. Their mental health issues were broken down into themes and sub-themes.

3.3. Several Mental Health Disorders

3.1.0. Anxiety

a. Worry

The families were facing an unknown future after experiencing such horrific violence, and now that they had relocated to Bangladesh. The children above the age of 12 stated that they have worked experience assisting families with construction and household tasks. They were not permitted to work at the campsite, though. Furthermore, many believe that obtaining an education at this age is unnecessary.

"I'm concerned about my future. What will become of me? What are my options now? Who will stand by me now that my parents are no longer alive? "Who will shoulder my burden?" — A 14-year-old male participant

"I'm worried about my family members. We have a huge number to feed and protect. It was difficult to support at home, and it is now considerably more difficult in here." — Male participant, 14 years old.

b. Restlessness

The majority of the children expressed their restlessness, which they called "Asanti" in Rohingya. The sentiment appeared to be widespread among adults as well. Different cultures and languages make them worry and feel uncomfortable with the NGO employees in the new camp setting. They become agitated in the presence of strangers.

c. Poor Concentration

Mothers of children under the age of ten stated that NGO workers attempted to encourage their children to attend school and receive an education. The children were initially placed in Temporary Learning Centres (TLCs). They had trouble concentrating, however. They exhibit poor concentration symptoms at home as well. One of the mothers stated that when her son was asked a question or given a chore, he seemed emotionless and uninterested.

"I see him being uninterested and immovable at times. He seemed to be deep in meditation. He no longer responds when asked why he is the way he is."

d. Panic Disorder

The majority of the children displayed panic disorder symptoms. Whenever the majority of the children under the age of ten witness Army personnel at the campsite, their moms report that the children become anxious. They take refuge in their home. Even the elder children struggled to deal with the Bangladesh Army personnel.

"One day, my son left the house for a few minutes and then returned. He appeared to be terrified and attempting to flee. He remained silent; his breathing labored. I became concerned and inquired about the situation. He was speechless. I hugged him and tried to make him feel better. He returned after a while, claiming that he had seen some soldiers around the camp." - a mother of an eight-year-old boy

The kids experience issues at night as well. The children are terrified because of the bad lighting, ventilation, and memory flashbacks.

"I'm unable to sleep at night. I'm afraid the military will return to kill me. Furthermore, the sanitation area has minimal lighting. I'm afraid to use the restroom at night." — A 14-year-old female child

3.4. Depression

a. Depressed Mood

The camp's children are frequently gloomy and depressed. They frequently claimed feeling unwell and having a restless mind. Furthermore, the lack of a playground for the children in the camps has caused them distress, since they are unable to feel normal in this unfamiliar circumstance.

"If there had been someplace for them to play or engage with other kids, they might have felt better," one of the mothers said. "They are uneasy being in this room with so many people. They are now frequently depressed."

"I am depressed whenever I recall those incidents. I'm not sure I could talk to anyone. Maybe if I could have told people how I felt, I would have felt better. However, most of us in the camp endured the same cruelty and suffering that no one ever talks about." – A 13-year-old female participant

b. Reduced Self-Esteem

The older children expressed a lack of self-confidence.

"Whenever I think about what happened to me that day," a rape survivor said, "I feel disgusting. I don't feel clean no matter how many showers I take. I'm always aware that others are judging me. They are discussing me. I'm not in the mood to leave the house anymore. I'm not in the mood to chat to anyone."

"Whenever I go outdoors, I feel like people are pitying me since I lost my family due to genocide," a 13-year-old boy stated. "What would have occurred if they were still living or if I had died as well? Maybe I wouldn't have had to suffer the agony of being alone."

c. Guilt & Suicidal Ideation

Children who lost their family in the genocide have expressed regret about their survival.

"I believe God is punishing me now because I did something wrong. I'm curious as to why they didn't kill me and my family after they removed my innocence. I'm afraid I'm no longer welcome in the neighborhood. I'm terrified to go outside now. My awful occurrence cut me off from the rest of my neighborhood. My own family has given me a moniker. My life has gotten just too difficult for me to bear." A 13-year-old female participant

"Whenever I think about what happened to my family and others in our community, I feel terrible. Overnight, one of my friends lost his home, family, and everything. He's now staying with us. When I look at him, however, I feel guilty. I believe I have at least my family with me, whereas he has nothing. I'm enraged by the army's treatment of him and us." –A 14-year-old male participant

"Rather than living like a parasite, I think I should end my existence. What good is it to live like this? In here, there is no home, no future, and nothing to claim as mine. I hope I could disappear. I'm always wondering why they left me alone. After rapping me, they should have murdered me. I would have been relieved of my suffering." A 15-year-old female participant

d. Loss of Enthusiasm

Mothers of children under the age of ten reported that their children do not go outside very much and that they lack motivation. They quickly lose interest and get confused and dejected due to a lack of playground and friends. Furthermore, remaining at home all day makes kids even less interested in whatever is presented to them.

4. Post-Traumatic Stress Disorder (PTSD)

a. Trauma & Flashback

The majority of the children have exhibited trauma symptoms. They would have reacted to the loud noise and the presence of an army soldier. They are disturbed by such situations and

refuse to speak to anyone at that time. They don't interact with other people. They were terrified when they saw outsiders. Rape victims in Myanmar were no exception. Stepping outside or talking with others is no longer an option. The unexpected noise surprised them. Occasionally, especially at night, the children get a memory flashback. They returned to the terrifying recollections that haunted them all the time in the quiet of the night.

"Whenever I think of what happened to us, I start quivering and crying in horror." "I can't seem to shake that horrible memory." –A 13-year-old female participant

"He can't get it out of his mind, and he's having trouble dealing with the outside world. He is constantly gloomy and jittery when talking with others." – A mother of a nine-year-old child explained

b. Nightmares

The majority of the children told the researcher that they were having nightmares. They had several nightmares over the incident they had witnessed. Because of this, they begin to scream and cry out loud in their sleep.

"He still has nightmares about the horrors he has witnessed after relocating to Bangladesh," a mother of an eight-year-old male participant said. "He cries and pisses on his bed at night because he is terrified. He's turned into a very peaceful child who rarely leaves the house these days."

c. Sleep Disturbance

The children were having problems sleeping due to nightmares and flashbacks of memories. Some people have described feeling disturbed before sleeping, such as remembering scary events and finding it difficult to fall asleep. Some people experienced nightmares and awoke screaming and thrashing in their beds. Their parents struggled to get them to sleep. Some people have reported feeling suffocated while sleeping and waking up. They were afraid to go asleep after that.

5. Somatic Symptoms

a. Palpitation & Sweating

When the children had a flashback or a nightmare, they reported sweating and palpitations, hyperventilating, and finding it difficult to remain calm. According to a mother of a nine-year-old child.

"Whenever he sees Bangladesh army soldiers, he hides in the house, sweats profusely, and hyperventilates. At that point, it's difficult to settle him down."

b. Loss of Appetite

The majority of the children stated that they did not eat as well as they should have. They have lost their appetite and have been reported as not wanting to eat.

"After we went to Bangladesh, my son had difficulties with the adjustment," A mother of eight-year-old children said. "He no longer goes outside to play, does not properly connect with others, has become quite quiet, and does not eat properly."

c. Pain & Fatigue

It was discovered that the children had pain or burning sensations in their bodies at night. In addition to the children's common symptoms, they cited headaches, leg discomfort, an injured area, weariness, and general bodily pain that could not be attributed to any intrinsic source.

6. Discussion

Children in the refugee community are exposed to many forms of violence and trauma, which are linked to severe mental health concerns such as depression, PTSD, and anxiety. Because of their age, children are particularly vulnerable, and emotional fragility can lead to mental problems, which can have long-term consequences in adulthood. Poor mental health is also linked to reduced educational attainment, poor quality of life, low self-esteem, and a slower decision-making process [10]. It was discovered that Rohingya children had been exposed to a variety of traumatic situations, including the death of family members, injury, displacement, and war; about half of them had been close to death (48.3%), faced close combat situations (41%), and over 40% had been tortured [11]. It resulted in a 5% increase in PTSD rates and a 30% increase in major depression rates [10].

After any severe form of trauma or tragedy, PTSD is one of the most serious psychopathological public health concerns. Children who are exposed to traumatic events, such as witnessing or experiencing them, extreme stress, disruption, and frequent nightmares, are more likely to develop signs of PTSD and other mental health disorders [12]. Though being clinically diagnosed with PTSD is not statistically significant, it does enhance the PTSD score as an outcome [10]. It was found in a study that exposure to trauma is linked to serious depression and depressive symptoms in 30 percent and 19 percent of people, respectively [10]. PTSD was found to be prevalent in females (64.7 percent) who had been sexually assaulted in studies (72.13 percent) [13]. Rape, rather than other types of trauma, has been linked to PTSD in several studies [12,14,15]. Furthermore, those who were physically exploited had a 72.55 percent higher prevalence of PTSD [14].

The current study discovered that exposure to violence and living in the World Health Organization's (WHO) lowest health-related quality-of-life category, where poor camp facilities can contribute to poor mental health to the children, such as depression [16]. The majority of Rohingya people developed depression after experiencing PTSD. According to research among the adults of the refugee camps, about 70% of Rohingyas suffer from moderate to severe depression, with 8.7% suffering from severe depression [16]. Low health-related quality of life and daily living stressors were the causes of such a high depression prevalence. Low mood, sadness, body ache, suffocation, losing interest in things, and other symptoms of depression were described by the Rohingya children and adults in the majority of the studies [17].

Suicide is the second largest cause of mortality among those aged 15 to 29, and in humanitarian crises like the Rohingya refugee camp, mental stress, restricted movement, sexual abuse, and

conflict can all contribute to suicidal behavior [18,19]]. Suicidal thoughts were prevalent in 13% of the population in the camp, and depression was prevalent in 89 percent [20]. Furthermore, the COVID-19 lockdown was linked to a greater probability of hospitalization in the refugee camps for suicide attempts [20]. The Rohingya population's faith-based apprehension to disclose suicidal ideation or attempt, fear of judgment and shame, and stigma associated with mental health conditions have resulted in a high proportion of suicide-related difficulties going unnoticed [17].

Another significant mental health condition among the Rohingya refugees is anxiety. The Rohingya refugee children were said to be experiencing mood swings and anxiety and despair symptoms. Palpitation, tremors, choking sensations, and excessive sweating was also reported by others, with no recognized cause that occurred frequently [21]. The flashbacks or nightmares of the events in Myanmar were the sources of these frequent panic episodes.

Apart from PTSD, depression, and anxiety, the Rohingya people also reported a significant level of somatic symptoms such as body pain, headaches, and back discomfort [22]. The majority of PTSD patients said they couldn't sleep, had lost their appetite, had sad thoughts and sensations, and were in pain. Majority of the children participants also reported such symptoms. Furthermore, many reported mental health issues such as spirit possession, black magic, and so on [22]. The study also discovered that the children frequently displayed bodily discomforts such as palpitation, perspiration, and tremors [21]. According to a case study, the individuals also suffered dizziness in addition to physical soreness [21,23,24].

6.1. Limitation

The study was taking place in a few Rohingya settlements in Kutupalong, Cox's Bazar. The study's purpose was to examine how Rohingyas' mental health is affected by the health risks they encounter. The study was initially limited to a few Rohingya camps in Kutupalong and Cox's Bazar, resulting in conclusions that could not be extended to all Rohingya refugee camps. The sample size was small due to a lack of time, funding, and political volatility. Due to time constraints, important information could not be gleaned from the brief interviews. The IDIs were short interviews as they were not thrilled to respond.

7. Conclusion

The mental health of Rohingya children in Bangladesh's Kutupalong camp was investigated in this study. The IDIs aided in understanding what the children went through from pre-migration to post-migration following the genocide they witnessed in Myanmar. The prevalence of PTSD, sadness, and anxiety among children is significant, but little research on the mental health of Rohingya children has been done. This study may be useful in identifying the critical need for mental health services focused on mental health counseling, various social interactive programs, and improving the living circumstances of children in Bangladesh's Rohingya camps.

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