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Factors Influencing Health Care Satisfaction among Rohingya Refugees in Bangladesh: An Analysis of 2019 UNHCR Data

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ABSTRACT

Rohingya refugees from Myanmar in Bangladesh face significant challenges in accessing health services. This study examines factors that influence satisfaction with the quality of health care services in the destination country, Bangladesh. The secondary data from the "Rohingya Survey 2019," which focused on social relationships, coping mechanisms, and views on relocation. The survey targeted 1,300 adults who arrived after August 25, 2017, with 1,277 respondents analyzed. Data were collected from March 1 to April 30, 2019, using quota sampling. Univariate, bivariate, and multivariate analyses, including binary logistic regression, were conducted to assess factors influencing satisfaction with health services. This study found that the majority of refugees were dissatisfied with health services. The key characteristics are female predominance among respondents, reliance on friends and neighbors for information, and dissatisfaction with the quality of education. All variables, including gender, news sources, perceptions of important figures, smoking habits, betel quid chewing habits, and satisfaction with education, were associated with satisfaction with health services. Multivariate analysis found that male refugees were 51% less likely to be satisfied with health services, refugees who received news from family were 69% less likely to be satisfied, and those who chewed betel quid were 30% less likely to be satisfied.

Key Messages:

- Rohingya refugees face health care challenges and struggle with legal status and social integration in Southeast Asia, despite international efforts.
- Rohingya refugees are largely dissatisfied with health services, with key factors including gender, news sources, and quality of education.
- Male refugees, those who receive news from family, and betel chewers are more likely to be dissatisfied with health services.
- Improving gender equality, communication channels, and quality of education could improve satisfaction with health care in refugee camps.

GRAPHICAL ABSTRACT

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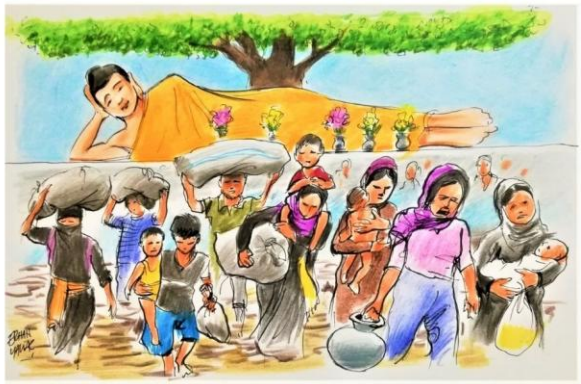

Source: https://www.dailysabah.com/opinion/columns/to-delay-justice-is-injustice-rohingya-crisis-and-bangladeshs-burden

INTRODUCTION

Healthcare access and quality are crucial determinants of refugees living in the camps. The Rohingya, a community experiencing a humanitarian crisis in Myanmar, have sought refuge in Bangladesh since 2017, after an increase in violence that resulted in more than one million Rohingya refugees fleeing to Bangladesh, mainly in the Cox's Bazar refugee camps (1). In the refugee camps, health services are one of the most pressing issues, due to the many challenges related to access, quality, and availability of adequate medical services (2). However, despite various efforts by international organizations and the Bangladeshi government to improve health services in the camps, challenges related to the quality of health services remain a significant problem for refugees (3).

After years of living in refugee camps, some of them have begun seeking a better life in neighboring countries. Some Rohingya migrants have fled the camps in Bangladesh and tried to reach other countries in Southeast Asia, including Malaysia, Thailand, and Indonesia(4,5). One of the main destinations is Aceh, Indonesia, which has become an important entry point for Rohingya refugees using the sea route to reach the country. In 2015-2025, thousands of Rohingya stranded in Aceh waters were eventually rescued and accepted by the Indonesian government as part of a humanitarian effort, although many of them continue to face challenges in obtaining legal status and social integration in their destination countries (6,7). The presence of Rohingya refugees in other low-middle-income countries reflects the tragic situation of those who continue to seek shelter outside Myanmar's borders, while international efforts to provide a permanent solution are still slow (8).

The quality of health services perceived by refugees can be influenced by various factors, including their social conditions, culture, and daily habits (9). Several previous studies have shown that refugees often face difficulties in accessing adequate health services, due to gender inequality, inadequate information, and different perceptions of medical authorities (10–12). Several factors that have the potential to influence refugees' perceptions of the quality of health services include gender, which often affects access to and acceptance of health services (13). Rohingya women have more limited access to health services compared to men, both due to cultural barriers and gender factors in decision-making. Sources of news, which can influence their knowledge and understanding of available health services, are another important aspect. For example, information received from social media or medical volunteers often determines refugees' actions in seeking medical care (14).

In addition, perceptions of important persons, such as community leaders or medical personnel, can influence their decisions in seeking care. Beliefs and views on medical personnel greatly influence the

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level of refugee satisfaction with the services they receive (15). Social habits such as smoking and chewing betel nuts can play a role in refugee health habits, which can have a direct impact on their perceptions of the quality of health services they receive (16). Several studies have shown that smoking and chewing betel significantly increase the risk of health problems among refugees, such as respiratory problems and oral diseases (17,18).

In addition to these factors, satisfaction with the quality of education is also an important aspect. Effective health education can improve individuals' understanding of the importance of maintaining health and following recommended medical procedures (19). Limited access to health education reduces public awareness of the importance of maintaining health and following correct medical procedures (20). Therefore, the level of satisfaction with the quality of education also affects refugees' perceptions of existing health services. This study aims to explore various aspects related to satisfaction with the quality of health services in Rohingya refugee camps in Bangladesh.

METHODS

This study utilizes secondary data analysis based on 'The Rohingya Survey 2019,' which provides valuable insights into the socio-economic conditions and challenges the Rohingya population faces. The survey aimed to assess the situation in Rohingya refugee camps from the perspective of adult Rohingya Muslims who arrived in Bangladesh after the August 25, 2017, military operation in northern Rakhine State. The survey focused on social connections, coping mechanisms, opinions about relocation to Bhasan Char Island, and future plans. The survey covered the Kutupalong, Balukhali, Thangkhali, Hakimpara, and Shamlapur refugee settlements in Cox's Bazar district, Bangladesh. The target population comprised 'new' Rohingya—those who arrived after August 25, 2017—aged over 18, residing in these camps. This population was estimated at 283,937 adults, based on UNHCR data as of March 15, 2019.

A quota sampling technique ensured representation across different camps and genders. The target sample size was 1,300 individuals, proportionally distributed according to the population and gender distribution in each camp. Enumerators, who were Rohingya refugees fluent in the Rohingya language, conducted the surveys. They were instructed to select respondents randomly within the camps; however, due to various constraints, true random selection was not always feasible. Consequently, while the sample is broadly representative, the potential for selection bias cannot be entirely excluded. Data collection occurred between March 1 and April 30, 2019. Enumerators translated questions and responses between English and Rohingya on the spot, which may have led to misinterpretations affecting the accuracy of some responses. Out of 1,455 surveys conducted, 1,277 were deemed sufficient for analysis. It's important to interpret data on sensitive topics, such as involvement in illegal activities or experiences of violence, with caution due to potential respondent bias.

This current study focused on satisfaction of health care quality as the dependent variable. The question is, "*How satisfied are you with the quality of healthcare you and your family are receiving in the camp*?". The authors categorized the answers to be dummy *satisfied and unsatisfied* form the original answers *very satisfied, satisfied, unsatisfied, and very unsatisfied*. The independent variables include sex (male/female), sources of news mostly, perception of important persons around, smoking status (no/yes), chewing betel nuts status (no/yes), and satisfaction with the quality of education. The variable of news sources was mostly defined from the question "How do you mostly hear about the news?". The variable of perception of important persons was "Who do you consider the most important person in your camp?". The variable of education quality was retrieved from "How satisfied are you with the quality of education you and your family are receiving in the camp?". After data management and data cleaning, the final total sample of this study was 1,276 refugees. The univariate analysis was done by testing the frequency and percentage of the total sample. A multivariate analysis using binary logistic regression was conducted to examine the effect of predictors on satisfaction with health care quality.

CODE OF HEALTH ETHICS

The dataset is open-access upon registration. All survey descriptions and datasets can be downloaded through the UNHCR: https://microdata.unhcr.org/index.php/catalog/434. The original

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survey obtained ethical clearance from UNHCR. This study uses secondary data (with anonymized data that cannot be traced back to the individual) and is exempt from new ethical approval.

RESULTS

The univariate analysis of this study (Table 1) revealed that most Rohingya refugees were not satisfied with the quality of health care in the camp (77.27%). According to sex, more than half of them were female (56.11%). Moreover, more than half of them reported that they got the news from friends and neighbors (65.75%). Regarding the perception of important persons, the highest percentage was reported by Block Mahji (45.92%). According to the smoking status, 19.75% of all refugees were smokers, and 57.60% chewed betel nuts. More than half of the refugees reported being unsatisfied with the quality of education in the camp (58.07%).

Table 1. The general characteristics of the refugees

Variables	n	%
Satisfaction with the quality of health care		
Unsatisfied	986	77.27
Satisfied	290	22.73
Sex		
Female	716	56.11
Male	560	43.89
Source of news		
Friends and neighbours	839	65.75
Family	178	13.95
Social media, newspaper, and radio	259	20.30
Perception of important persons		
Block Mahji	586	45.92
CIC (CAMP IN CHARGE)	359	28.13
Head Mahji	309	24.22
Others	22	1.72
Smoking		
No	1024	80.25
Yes	252	19.75
Chew betel nuts		
No	541	42.40
Yes	735	57.60
Satisfaction of quality of education		
Unsatisfied	741	58.07
Satisfied	535	41.93

Table 2 below describes the bivariate analysis results of the association between predictors and satisfaction with health care quality. It revealed that all independent variables have an association with satisfaction of health care quality, including sex, source of news, perception of important persons, smoking, chewing betel nuts, and satisfaction with the quality of education. According to the Chi-square test result, all the tests were found to have a p-value < 0.05.

Table 2. The Chi-square test of association between predictors and satisfaction of health care

Variables	No (%)	Yes (%)	Total	Chi-square	*p-value*
Sex				14.4848	<0.001
Female	53.25	65.86	716		
Male	46.75	34.14	560		
Source of news				14.0787	0.001
Friends and neigbours	64.3	70.69	839		
Family	15.92	7.24	178		
Social media, newspaper, and radio	19.78	22.07	259		
Perception of important persons				38.274	<0.001

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Variables	No (%)	Yes (%)	Total	Chi-square	*p-value*
Block Mahji	49.9	32.41	586		
CIC (CAMP IN CHARGE)	24.44	40.69	359		
Head Mahji	24.24	24.14	309		
Others	1.42	2.76	22		
Smoking				5.74	0.017
No	78.8	85.17	1,024		
Yes	21.2	14.83	252		
Chew betel nuts				14.372	<0.001
No	39.55	52	541		
Yes	60.45	47.93	735		
Satisfaction of quality of education				44.742	<0.001
Unsatisfied	63.08	41.03	741		
Satisfied	36.92	58.97	535		

Table 3 below offers the multivariate analysis of the effect of predictors on health care quality satisfaction. It was found that, compared to female refugees, male refugees had 51% lower odds of being satisfied. Refugees who got the news from family had a 69% decrease in the probability of being satisfied compared to refugees who got news from friends and neighbors. Additionally, compared to those who had the perception that Block Mahji was an important person, the perception of camp in charge (CIC), head Mahji, and others was 2.67, 1.88, and 4.34 times more likely to be satisfied with the health care quality. Compared to those who did not chew betel nuts, those who chewed had a 30% decrease in the probability of being satisfied. Moreover, compared to those unsatisfied with education quality, those satisfied with education quality were 2.82 times more likely to report satisfaction with health care quality.

Table 3. The multivariate results of the effect of some aspects on health care quality satisfaction

Variables	AOR	95% CI (lower - upper)		*p-value*
Sex				
Female	ref			
Male	0.49	0.34	0.73	**<0.001**
Source of news				
Friends and neigbours	ref			
Family	0.31	0.19	0.52	**<0.001**
Social media, newspaper, and radio	1.41	0.94	2.10	0.093
Perception of important persons				
Block Mahji	ref			
CIC (camp in charge)	2.67	1.90	3.74	**<0.001**
Head Mahji	1.88	1.29	2.75	**0.001**
Others	4.34	1.67	11.25	**0.003**
Smoking				
No	ref			
Yes	1.04	0.66	1.62	0.867
Chew betel nuts				
No	ref			
Yes	0.70	0.53	0.93	**0.013**
Satisfaction with quality of education				
Unsatisfied	ref			
Satisfied	2.82	2.11	3.76	**<0.001**

Note: *AOR (Adjusted Odds Ratios), CI (Confidence Interval)*

DISCUSSION

One of the key findings of this study is the gender gap in satisfaction with health care services. Specifically, male refugees were found to be 51% less likely to be satisfied with the health care services they received compared to female refugees. This is consistent with research showing gender differences in satisfaction with health care services in refugee populations. Women, particularly in marginalized communities, often report higher satisfaction with health care services due to the cultural and emotional

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support they receive, as well as better access to health care services (21). In the context of Rohingya refugees, it is possible that women, due to their role as caregivers, may have more direct interactions with health care providers and be more involved in seeking and receiving care for their families (22). Additionally, women may be more likely to express dissatisfaction or satisfaction based on a broader understanding of health care services that includes not only medical care but also emotional and community care, an aspect that is often underrepresented in men's perspectives (23).

Another important finding was that refugees who received information about health care through family members were 69% less likely to be satisfied compared to those who received it from friends or neighbors. This finding suggests that the source of health care information may have a profound impact on satisfaction levels. Previous studies have shown that communication channels play a significant role in perceptions of health care. Interpersonal networks, especially peer groups such as neighbors and friends, tend to facilitate the exchange of more reliable and accurate information, leading to higher satisfaction with services. In contrast, family-based communication can often be burdened with subjective bias or misunderstanding, which can negatively impact satisfaction levels (24). Theoretical perspectives on social networks highlight the importance of bridging social networks (such as those with neighbors or friends) in providing valuable and diverse information that contributes to better health care outcomes (25).

The study also found that refugees who considered the Block Mahji to be the most important person in the camp were less likely to report satisfaction with health services, whereas those who considered the Camp In-Charge (CIC), Head Mahji, or other leaders to be more important were more likely to report higher satisfaction. These findings suggest that local leadership plays a significant role in shaping refugees' perceptions of health service quality. This is consistent with the previous work that refugee populations are often influenced by local authority figures in their communities, as these leaders mediate access to essential services and act as trusted intermediaries between refugees and humanitarian organizations (26). From a theoretical perspective, this is consistent with social capital theory, where trust in community leaders can increase access to and satisfaction with services, as these figures often serve as gatekeepers and influencers of resource distribution and information flows (27). The study also identified that refugees who chewed areca nut were 30% less likely to be satisfied with health services compared to those who did not. This may reflect cultural factors or health practices that influence perceptions of health service quality. Areca nut chewing is common among many populations, including the Rohingya, and is often associated with specific cultural practices. However, it may also indicate a possible disconnect between cultural health practices and the formal health care system. These findings call for broader discussion of cultural competence in health care systems, highlighting the importance of integrating cultural practices into health care delivery to improve satisfaction and acceptability. Theoretical frameworks, such as cultural competence theory, emphasize that health care systems must respect and understand cultural practices to improve health care delivery and outcomes (28).

Finally, the study found that refugees who were satisfied with the quality of education were 2.82 times more likely to be satisfied with the quality of health services. This finding underscores the interconnectedness of satisfaction with multiple services in refugee settings. It suggests that satisfaction with education and health services may be linked through broader dimensions of well-being and empowerment. A study, showing that satisfaction with one type of service (such as education) often spills over into other services, especially when these services are perceived as important to the overall well-being of individuals and families (29). This relationship can be explained through the concept of holistic health and well-being, where access to quality education enhances an individual or community's capacity to navigate and utilize health services more effectively (30). Furthermore, theories on the socio determinant of health emphasize that factors such as education can significantly influence perceptions of health services, as individuals with higher levels of education are often better equipped to understand and assess the quality of the services, they receive (31). It found insignificant findings from multivariate analysis, such as smoking status and social media news sources. However, smoking and reliance on social media as a news source were found to be associated with satisfaction of health care services in the bivariate analysis. This lack of significance in the adjusted analysis may be attributed to confounding variables that better explain the variation in satisfaction levels.

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Some limitations of the study affected the interpretation of the findings. The respondents might be afraid to report due to the sensitive topic of home and destination countries. Additionally, males were found to be less satisfied, maybe because they utilized less compared to females. Additionally, the news comes from the family affected, who are less satisfied because they are more trusted compared to friends or neighbors. This current study suggested practical implications for humanitarian organizations and policymakers in the camps. These details might strengthen communication, collaboration with leaders, and apply the cultural approaches.

CONCLUSION

In conclusion, the findings of this study highlight the complex interplay between gender, communication sources, leadership perceptions, cultural practices, and education in shaping Rohingya refugees' satisfaction with health services in Bangladesh. The results not only provide insight into the specific context of this refugee population but also align with broader theoretical and empirical findings in the area of health service satisfaction. Further research is needed to explore these relationships in more depth and to inform the development of culturally sensitive, community-based health service interventions that can improve the well-being of refugee populations. The specific research such as ethnographic, would be clearer to explain the sociocultural aspects.

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CONFLICTS OF INTEREST

All of the authors declare no conflict of interest in this study.

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