**Gender Based Trauma in Rohingya Crisis and Ethical Dilemmas of Public Health Practice**

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**Abstract:**

*Since August 2017, more than a million Rohingya have fled to Bangladesh seeking refuge from their past habitat Myanmar. They experienced severe violence- both physical and psychological which was much higher in magnitude among the girls and women. The severity of gender-based violence continues to rise even after reaching Bangladesh which is evident in reports informing child trafficking and forced prostitution. Ongoing public health efforts to treat the Rohingya and prevent future diseases leave the issue of gender-based violence unaddressed. This scenario creates a serious of ethical dilemmas including impaired autonomy, inappropriate beneficence, lack of justice and unprotected human rights for the Rohingya girls and women. Without compromising the existing measures, the policy makers and practitioners should recognize the burden of gender-based violence, assess the types and extent of the same and adopt evidence-based approaches to treat and prevent the cases of such violence as well as overcome the ethical concerns.*

In 25 August 2017, Military and paramilitary forces of Myanmar launched ‘clearance operations’ against Rohingya population in the Rakhine State of Myanmar (1,2). An estimation by *Médecins Sans Frontières* (MSF) reported that the number of deaths crossed 9000 within the first 31 days of this humanitarian crisis (1). In addition to mass murder, other crimes against humanity including physical torture, rape and other forms of sexual torture, kidnapping etc. continued to happen to Rohingya living in Myanmar (3). Residences were burnt and thousands of Rohingya became victims of extreme violence. Those who could escape from such mass atrocities, tried to cross the border between Bangladesh and Myanmar to seek refuge at Cox’s Bazaar district of Bangladesh. Many of them faced danger on the way, many people drown in the river and despite all these difficulties and nearly half a million Rohingya reached Bangladesh within September 2017 (3,4). Since then, the number of refugees has been increasing every day and local as well as international agencies are facilitating them with basic living amenities and medical care. Sooner, the refugee camps has become overcrowded and the local authorities continued to expand the camps forming one of the largest refugee camps in the world. Now, more than a million Rohingya are living in these refugee camps in Bangladesh and their physical and mental health status is a global concern for immediate action (5,6). However, these issues create the tip of the iceberg whereas a series of crises after the initial crisis appear sequentially.

Although the acts of violence left none behind and affected all Rohingya irrespective of their physical or socio-political orientation, the magnitude of violence was much higher among the adolescent girls and women at reproductive age (3). The bullets didn’t consider the gender of a victim but those who fired the same did so. Incidences of rapping girls and women in front of their families, kidnapping them to unknown places from where they never returned and killing them brutally after sexually abusing them- were witnessed and reported by the Rohingya refugees (3). Few of them managed to secure asylum in Bangladesh but life was not easy for them even after months of the actual violence. A normal married or social life is far beyond the imagination of a poor girl who was physically abused earlier (3). The families as well as the communities could not do much to foster happiness to these girls and women who experienced horrible acts of violence in their lives. In addition to the physical trauma, psychosocial abnormalities affect their health and wellbeing. The spectrum of gender based violence results adverse reproductive health outcomes, sexually transmitted diseases and mental health disorders (7). Their vulnerable status and health conditions are poorly recognized and managed by the healthcare professionals for several reasons- their language is different than the local language; most of them are illiterate, therefore, they cannot communicate in a English or any other second language; and the stigma encompassing physical and psychological violence makes it harder to express the real scenario to the caregivers (8). Further, the girls and women who are already vulnerable by their past illness and exposure to violence- are more prone to become victims of child trafficking and forced prostitution (9). Moreover, there is no baseline study to understand the intimate partner violence and the status of women empowerment as well as gender equity among the Rohingya population. Therefore, different dimensions of gender based violence are affecting the lives of half a million girls and women which remains beyond assessment and management by the public health workforce. There are very few reports that inform about the problem but there is no study or report that highlights the magnitude of these issues and facilitate the policy makers to protecting the individuals and preventing further violence which not only affect the victims but also their families and the future of all. Therefore, the past and present exposures to gender based violence against Rohingya girls and women form a great threat to the humanity which demands adequate public health investigations to measure the problem, determining as well as protective factors, outcomes and impacts of such violence on population health and existing measures to address the issues. While these remain valid pursuits to chase from a public health perspective, the current focus of public health agencies and other allied institutions is on treating physical trauma and frequently reported diseases (10). Simultaneously, measures for infectious diseases like diarrhoea, hepatitis, vector borne diseases like malaria, dengue and chikungunya are being taken (10). Also, the agencies are working collaboratively to ensure vaccination against polio, diphtheria, cholera, measles and rubella (10). These efforts are improving the overall health of Rohingya and principle of beneficence is ensured from that perspective. But the same principle is challenged in case of those who remain silent about their trauma and remain most vulnerable among the vulnerable population- the girls and women who are victims of gender based violence (11). It is immensely necessary to understand how to perceive when their autonomy to live a fulfilling life is being traded undermining the legal, social and psychosomatic consequences of the same. Such trading of autonomy during a complex humanitarian crisis is a critical threat to the ethical paradigm the public health practitioners need to consider (12).

Another ethical issue is how the collective approaches justify the way they take care of the victims of gender based violence (13). Fundamental questions arise from this scenario includes: The way the magnitude of an infectious disease is measured, do they measure the severity of gender-based trauma similarly? Do they give equal priority in serving the victims of such violence compared to the patients suffering from other diseases? These questions determine the discourse of a further discussion on violating the distributive justice whereas the way the existing measures handle the identified cases might require further inquiry on procedural justice (14). Inevitably, a lack of justice in identifying, treating and preventing the cases create opportunities for those who utilize the loop-holes of the crisis and continue their unethical practices of girl trafficking and forced prostitution. Furthermore, the community-based perceptions are greatly affected in increasing trend of such incidences and the absence of timely and adequate measures diminish their hope about the future of girl child among their families. In the patriarchal social structure, early marriage of girl child is often considered as a mean of social protection, which again affects the fundamentals of autonomy of the girl in deciding her own choices in making family (15). Therefore, such structural violence is often imposed by the social institutions which makes the situation more complex to deal with (16). With obvious consequences like being deprived of education, low wages in the labour market, lack of access to healthcare, teenage pregnancy and poor quality of living- create a vicious cycle for a Rohingya girl who suffers from the untreated social disease of gender-based violence which is not addressed with utmost possible ethical considerations (17). Sociocultural norms to such a serious public health concern, persistent gender inequality, lack of choices to the individuals and the communities, unavailability of required support, absence of affordable and accessible care, unacceptable post-conflict structural systems of socioeconomic protection and lack of institutional accountability fails to protect the fundamental human rights (18,19). Thus, the ethical concern on the principle of human rights to the Rohingya girls and women, now and in the future, remain a challenge for the global health fraternity.

To overcome all the ethical concerns discussed above and eradicate the underlying crises of gender-based violence beneath the layer of overall Rohingya crisis, adoption of evidence-based strategies in measuring the problems and mitigating the challenges in addressing them is a need of time (20,21). The first part of assessing the problem requires extensive yet quick formative research with utmost consideration of ethics of research that predominantly applies to the subjects who experienced or exposed to gender-based violence (22). Concerns on human subject research particularly for vulnerable population like refugees, women and girl child, and people with lack of access to the basic amenities enable the researchers, ethicists, policy makers, practitioners and other key stakeholders to design research initiatives in a better way (23). However, the previous lessons of gender-based violence to refugees can inform the differences and provide the basis of outlining more context-specific protocols. Further, the findings of past, present and future researches are subject to be translated in to practices which is the key to improve the scenario. In a conflict-prone area which suffers from resource-constrains and several challenges like lack of specific protocols and policies to serve the population demands, translational approaches would be challenging to implement (24). A multipronged approach involving local and global providers to mobilize their collective resources to ensure a holistic wellbeing of Rohingya population is required. The policy makers have a leadership role to include specific provisions of protecting the victims of gender-based violence which will allow the institutional providers at the community level to be sensitized about the facts and enhance their competencies to serve the target population safeguarding the ethical considerations. These institutional and community providers working on different realms including health, education, social welfare and so one have their own ways to contribute to the overall protection of the target population they are destined to serve, however, the ethical fundamentals apply to all the aspects they cover in their practices. For instance, reducing the gender discrimination in all the transactions, minimizing the prejudice and stigma to the violence and overcoming cultural negativities are critical to promote equality and justice which must be addressed in a collective manner (25). Increasing the participation of the victims in the prospective measures would require community empowerment and profuse public health advocacy. In addition, their privacy and confidentiality should be protected by the practitioners for protecting them from further exposure to violence which is not uncommon in practice (26). Being sensitive to issues related to conscientious objection facilitates the processes of protecting the victims and allowing the providers to increase the access to care. Also, the planners should adopt standard guidelines to minimize the errors in care and maximize the quality of services. Such standardization of the approaches and practices would increase the accountability as well, which would promote the trust on the system and help the victims to step out of their miseries. Furthermore, the health system of Bangladesh should come forward along with other public agencies in ensuring the medicolegal protection of the victims. In addition to protecting the victims from the past or ongoing trauma, futuristic approaches should be considered to strengthen the system which can serve ethically under complex circumstances. Addressing the gender-based violence in Rohingya would provide meaningful insights in resolving similar crises in South Asian countries originating from population dynamics as migration (27,28).

To conclude, a critical humanitarian crisis requires urgent attention to the local, regional and global communities to protect their lives and foster a harmonized and healthier future and Rohingya crisis is no exception. Within the existing health and social hazards faced by the Rohingya population, gender-based violence both before and after being refugees, has created a set of ethical dilemmas in serving them. Least is known about the real magnitude of the problem and handful efforts are taken to solve the same which breaches the ethical boundaries further and affects their lives in many ways. The status and sufferings of girl and women in the socio-political perspectives challenge the protective approaches to be designed and implemented. Though there are challenges to do so, the consequences of not doing the same show numerous population-based problems and subsequent social and health hazards which imply greater burden to all. Realizing the severity and the willingness to prevent the unbearable crises in the future are essential to take right approaches in the right time in the right way without compromising remaining public health priorities. Therefore, the ethicists and public health leaders should play an active role in bringing all the players and their respective resources in resolving the ethical, medical, psychological, legal, economic, social and all other challenges to Rohingya girls and women that they face for the historical maldistribution of power around themselves, even in the darkest hours of in the state of statelessness.

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