# FLASH REPORT

# Rohingya Experiences of Covid-19 in Cox's Bazar Camps

**July 2020**

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# EXECUTIVE SUMMARY

The Political Settlements Research Programme (PSRP) is based in the Law School of the University of Edinburgh, in Scotland. The PSRP supports communities who are experiencing, or have experienced, violent conflict. The Programme conducts research that is broadly concerned with inclusion in peace processes and an end to violent conflict, and it also hosts the 'PA-X' database on global peace agreements. In response to Covid-19, the PSRP is carrying out a new cycle of research that explores how vulnerable populations are affected by the pandemic. This Executive Summary provides an overview of findings from a flash report on community experiences of Covid-19 in Rohingya camps in Cox's Bazar, Bangladesh. Authored by three researchers who live in Cox's Bazar and based on 34 interviews with camp residents, the study examines five dimensions of Rohingya experiences of the pandemic.

### (1) Awareness and understanding of Covid-19

Many camp residents have a very basic understanding of Covid-19, but are lacking information on the specific actions they can take to protect themselves, and their families, from the spread of the virus in the camp setting. Respondents to the study proposed that messaging by megaphones in camp gathering spaces has a limited reach, particularly for female camp residents who are often based inside the home and missing the messages. Some respondents suggested that door-to-door information campaigns are needed in order to correct rumours and misunderstandings, and to convey clear messages to all camp residents. A further finding is that even where community members have an accurate understanding of Covid-19 and its transmission, they still lack essential items that would help them stop the spread: such as masks, clean water, and soap.

### (2) Impact of Covid-19 and lockdown on livelihoods

With the arrival of Covid-19 in Cox's Bazar, the livelihoods of many individuals residing in the camps were adversely impacted – especially shopkeepers and those with public-facing businesses who could not function while maintaining physical distancing. The serious challenges people faced with respect to their livelihoods also exposed that many individuals do not simply rely on assistance given by the international community; instead, they count on access to local markets and on job opportunities to ensure adequate income and food for their families. This point is crucial in light of recent moves to decrease humanitarian services in the camps to 'critical services' only.

### (3) Impact of Covid-19 and lockdown on family relationships and communication

Many community members reported that the lockdown had severely constrained their ability to communicate with others. The increased restrictions on movement particularly affect people who have no phone and rely on in-person visits with family. Internet access has been restricted in the

camps since September 2019; movement and communication restrictions thus create an additional layer of difficulty for camp residents already coping with crisis and social isolation. The restrictions on movement also prevent community members from seeking routine social support from friends and family – not only for coping with covid-19, but also for the daily challenges of life in the camps. The lack of contact further poses an obstacle for dealing with crisis situations that arise, as when shelters are destroyed due to natural hazards and people wish to seek the support of family.

### (4) Perceptions of medical clinics and hospitals

Camp residents have been reticent to seek testing, isolation and treatment for Covid-like symptoms in the health clinics and hospitals that are available to them in the area. Interviews revealed that many fears and rumors have spread in the camps about ill treatment in the clinics and in isolation facilities: some community members even think they will be killed by the doctors in these clinics, rather than helped. In the early days of lockdown, rumours circulated that community members who were found to have Covid-19 at the clinics would be 'disappeared' or sent away without their families being able to find or contact them. The lack of trust between community members and the medical actors running the clinics poses a serious obstacle for attempts to stop the spread of the virus and to treat those who contract it. All of the beliefs and (mis)perceptions reported in the study suggest that more is needed in terms of messaging about Covid-19 in the camps, and the dissemination of accurate, reliable information about the clinics in particular.

### (5) Messages for (international) humanitarian agencies and government actors

In many of the interviews conducted for this study, respondents expressed distrust and noted a lack of open communication between themselves and humanitarian agencies working in the camps – both national and international agencies—as well as governmental authorities. Religious leaders expressed a desire that humanitarian agencies would take more advantage of their community links, and let them be a bridge between humanitarians and camp residents. Community members were also critical of the practices of some NGO workers in the camps. On the one hand, some NGOs failed to wear masks or to maintain appropriate physical distancing when interacting with camp residents. Community members felt that this set a bad example for how those living in the camp are supposed to behave in order to stop the spread of the virus. On the other hand, where NGO workers did wear protective gear when interacting with camp residents, the latter had the impression that because they do not have access to these same materials (gloves, mask, etc.), they could hope to protect themselves properly.[1] It is evident that community members sincerely desire more opportunities to play an active part in decision-making about how Covid-19 will be dealt with in the camps, as with all decisions that affect their daily lives.

[1] There is an initiative underway to provide 2 masks to every individual in the camps.

## Background to the Report

This flash report was compiled by three community-based researchers interested in learning community perspectives on Covid-19 in the Rohingya refugee camps of Cox's Bazar, Bangladesh. On May 14, 2020 the first case of Covid-19 was reported in the camps. As of early July, some 740 Rohingya refugees have been tested, with 54 found positive for the virus.[2] While the spread seems to be under control for the time being, the risk of infection, and secondary effects of the pandemic (*e.g.* on livelihood and other aspects of camp life) remains high.

The views expressed in this report are those of community members in the camps including youth, elders, women, religious leaders, informal pharmacists, and recovered Covid-19[3] patients. Responses were collected throughout the months of May and June, and this report draws on **34 interviews** in total. Of the interviews conducted, 5 respondents were female, 29 were male, 5 were religious leaders, 3 were community doctors, and 17 were youth.

The findings of the report were developed through a **community-driven project** based on 'participatory action research' methods. In an effort to 'flip' traditional Western research methods in which international researchers conduct investigations themselves—or rely upon locals as fixers, assistants or enumerators—the project centers local researchers who live in the camps of Cox's Bazar. Two of the three researchers who authored this report are youth. Together, they scoped the research project, developed a series of research questions based on their assessment of community needs, and conducted the interviews with their fellow community members. International researchers played a supporting and coaching role, helping to guide the research remotely, assisting when the research process faced challenges, and editing this report. In the interests of security, the identity of all respondents who were interviewed for this report has been anonymized.

The report focuses on **five themes** of community experience in the camps during the Covid-19 crisis: (1) Knowledge, understanding and perspectives of Covid-19; (2) The impact of Covid-19 on livelihoods; (3) The impact of lockdown on relationships and communication; (4) Perceptions of medical clinic and hospitals; (5) Concerns to share with (international) actors responding to the pandemic.

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[2] The World Health Organization reports that as of 13 July 2020, 981 tests for Covid-19 had been conducted for camp residents, with 57 Rohingya testing positive. In the host population, 17,468 individuals were tested, with 2,973 individuals testing positive. As of that date there were 5 reported Rohingya deaths and 42 deaths in the host population attributed to Covid-19.

[3] This report primarily refers to the virus as Covid-19. An exception is the excerpts from community interviews, in which the terms Covid, Covid-19, corona and coronavirus are used interchangeably.

## (1) Knowledge, understanding and perspectives of Coronavirus

How do residents of the camps in Cox's Bazar come to learn about Covid-19, and what is the extent of their understanding of the virus and how it spreads? This part of the report explores these questions, sharing community perspectives as the first covid-19 cases were arriving in Cox's Bazar.

When asked what they know about Covid-19, most people interviewed expressed that they had **limited knowledge**. A majority of respondents were aware that the disease is highly contagious. Many also knew that spread could be mitigated through physical distancing; by avoiding large groups; and by following hygiene precautions, especially hand washing. Some respondents were unclear about why they had just recently begun hearing about the virus, which was not a concern when they were in Myanmar.

Overall, respondents felt that they lacked substantive information about the virus, though they gained a basic understanding through various sources. Some residents with limited mobility had learned basic information through megaphone messaging. According to a 61-year-old woman with limited mobility in Camp 1:

> As I am old and prone to diseases, I do not go outside and I do not know much about the virus. I only know that some organizations are spreading awareness using megaphones, on how we should avoid it. My husband is very old; he doesn't get out too often and cannot attend prayers at the *masjid*. So, he doesn't know about the virus either.

However, the woman said, she was able to learn about the virus through a neighbor who had experience working for a humanitarian agency:

> There is a WFP [World Food Programme] volunteer whose shelter is next to me. I frequently go to his shelter. I saw his wife with a mask and saw that their children were washing their hands often. I asked why, and she told me about the coronavirus. She told me that in almost all countries in the world, there is a lockdown to prevent this disease from spreading.

Like this woman, other camp residents also referred to learning about Coronavirus from "educated people" and NGO volunteers in the camps. This often occurred informally, however, and not through direct programming and official messaging. Another woman, a 19-year-old in Camp 1, learned about Covid-19 from her sister, an NGO volunteer:

> My sister worked for the UNHCR TAI [Technical Assistance Inc.] office. Every day, I could see my sister practicing handwashing with soap. She told me about Covid-19. This is a very serious disease that can affect mostly elderly people.

Many respondents said that **door-to-door information campaigns** by humanitarian agencies would be helpful, and this was cited as especially important for reaching women, as many spend their time inside the home. It was also noted that internet access would enable people to watch videos and learn about Covid-19. Several observed that others in camp are not following preventive guidelines, asking NGOs to play more of a role:

> We appeal to all humanitarian agencies to advocate to the government and convince our community people to control the disease, because our community has little knowledge about Coronavirus and how it affects us. More importantly, NGOs need to distribute all necessary tools to prevent the spread of Coronavirus.

More effective communication is especially important in light of the **(mis)perceptions** that community members hold about Covid-19 and its transmission. As will be shown in Section 4 of the report, the hospitals and clinics are viewed by many camp residents as dangerous places (rather than places to seek out in the event that they experience symptoms). Many of those interviewed also believed that Covid-19 had religious origins, and some also linked the virus to the Rohingya crisis. One individual said:

> We can also say that this is a punishment from Allah so that people change their mind to prayer. The disease will disappear from the world if the world community pays attention to solve the Rohingya crisis.

Another respondent also saw the virus itself as a punishment for the world's failure to bring about justice for the Rohingya cause, and that the only way to stop the spread of Covid-19 was for the world to 'serve justice for the Rohingya as soon as possible'. This person shared the belief that it would not actually be Rohingya who were ultimately harmed by Covid-19, but rather it would spread to other people – namely those who did not assist with securing justice.

A few people interviewed were also **unconvinced that the virus is real**. According to some youth, elders are less likely than younger people to believe in Covid-19. They attribute this to elderly people's lack of familiarity with modern science and public health. As one 80-year-old man said:

> **Coronavirus? We don't have that here.** But we heard that in some places people are facing the disease. [I think] that is because people are not obeying Almighty (Allah's) order. This is a lesson learnt for us. I didn't hear about it and I have no knowledge. While we were in Myanmar we did not hear about this kind of disease but after over two years staying in the camp we have this disease.

Several **religious leaders** interviewed embraced both religious and scientific perspectives, highlighting the Quranic teachings on community management of contagious disease. According to one Moulana, who had homeopathic training and a religious degree:

> Prophet Mohammed (SWAS) ordered people at that time if any serious disease that may affect others happens to you, “You should not go to other places avoiding this disease. But stay safe at your current location so that you cannot affect others.” The rules by the government orders regarding the disease must also be respected.
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> Now, we are facing Covid-19. We should obey the government’s instructions on handwashing with soap every 30 minutes, wearing face masks, social distancing, using cloth or tissue while coughing and throwing betel nut and saliva into the dustbin. The problem with our community is people’s lack of knowledge on it. We should provide more awareness on it to disseminate messages to the people.

The above perspectives suggest that while a belief of Covid-19’s religious origins may lead to a sense of fatalism amongst community members about contracting the virus, it is also the case that religious leaders play an important role in disseminating information to community members about the importance of hygiene and physical distancing to stop the spread of Covid-19.

## (2) The impact of Covid-19 on livelihoods

With the arrival of Covid-19 in Cox’s Bazar, the livelihoods of many individuals residing in the camps were adversely impacted – especially shopkeepers and those with public-facing businesses who could not function while maintaining physical distancing. The serious challenges people faced with respect to their livelihoods also exposed that countless individuals do not simply rely on assistance given by the international community; instead, they count on access to local markets and on job opportunities to ensure adequate income and food for their families. This point is crucial in light of recent moves to decrease humanitarian services in the camps to ‘critical services’ only.

Many of those interviewed expressed that they **had had no income prior** to the pandemic, and still had none, so they were not made worse off financially. But they expressed an urgent desire for expanded work opportunities, a desire which preceded the pandemic.

For those who did rely on a livelihood prior to the arrival of Covid-19 in the camps, the effects were often devastating. According to an **imam,** the pandemic has negatively impacted his livelihood, which was already facing challenges:

> I am an Imam of a *masjid* in our block. Normally I didn't get enough salary monthly from the community contribution. I get only 2500 taka per month. As the block people have no income during the lockdown time, even the people cannot contribute that amount. So, it affected my daily income. I don't have any other business.

On April 8, a directive from the Bangladesh government forced the camps into a lockdown to mitigate the spread of Covid-19. A **shopkeeper** explained how his business had been negatively affected as a result, noting that fines had been levied against shopkeepers who stayed open:

> This year, especially during Ramadan, I could not sell items properly. I could not open my shop freely as authorities are patrolling in the camp. Before, I could do 2000 taka of sales per day, but now it's only 500 taka. It is totally reduced. Because of this, shopkeepers cannot order inventory from outside, so our prices are higher. Last week, police arrested my friend, a shopkeeper, for opening his shop. He was arrested and paid 5000 taka to be released.

Another shopkeeper concurred that business has decreased, noting that he relied upon this business to supplement the rations received by the international community:

> … I have a shop and was able to live by means of the shop before the lockdown. But since the lockdown was announced, I couldn't open the shop. It has been about three months now. I have kept my shop closed due to the lockdown. It is strictly prohibited...Due to the lockdown, daily items like fish, vegetables, snacks, and other necessary things became higher priced. And things are not available as before.
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> Due to the lockdown, people cannot travel much and bring things from outside of the camps. Rations are being given but they are not quite enough for us to live on. We cannot share or explain this difficulty to anyone. Even though the rations are not sufficient which we are getting, somehow, we are managing to live on the rice with lentils with salt. We are living and leading our families this way.

Many people expressed anxiety about their reduced sense of **food security**, pointing to a reduction in services by international humanitarian agencies, and the withdrawal of NGOs in response to the Covid-19 outbreak. Access to clean water was a particular concern, as was access to varied food choices. One person said, "We want to eat protective, energetic foods that are body-building, but we can't." Another explained:

> …I lost everything. Due to the lockdown, I can't go anywhere for anything, so it's become very difficult for me to support my family, and I have many family members. We are just getting rice and lentils from the NGOs, but I have to support [my family] as I am the breadwinner. I need to buy fish, chili and vegetables from outside with my own money, as we are used to consuming these like before in Myanmar. My family members and I can't live on lentils continuously…

Some **day laborers** performing informal work said they had also lost work and income, partially due to movement restrictions but also lack of opportunities. Former NGO volunteers said they were laid off due to the crisis. One NGO volunteer who had lost his job during Covid-19 recognized that this economic downturn is not only limited to the camps, but a global phenomenon:

> The entire world has stopped, nobody has work now to do. The people who have had some savings before the lockdown, but those savings have all been spent and finished now.

A further consequence of the global scope of the pandemic is that some camp residents no longer receive remittances from family members abroad as the livelihoods of the latter have also been impacted.

The concerns about livelihoods and income cut across many dimensions of life in the camps. A 40-year-old **teacher** describes the negative impact Covid-19 has had on his life as a whole:

> During the lockdown in the camp we have no hope, rations have decreased… [T]he family doesn't have enough family food, and NGOs and agencies are not sending full rations on time. During the lockdown our daily work is stopped and we can't teach students, so I have not received any salary since the beginning of lockdown. Sometimes we want to take our children to private health clinics but can't due to lack of income. And we can't pray in groups in the mosque.

An exception here is the situation of **community doctors** in the camps, many of whom are receiving increased business because of Covid-19 as camp residents seek out their services. The practices of these community doctors in the camps are controversial: as they do not have formal training and are not allowed legally to practice medicine, they generally practice in secret. This issue will be revisited briefly in Section 4 of the report (hospitals and clinics) and in the final report for the project.

A further impact that Covid-19 and the resulting lockdown has had on camp life, that is less tangible and difficult to quantify in comparison to livelihoods, is the challenge it poses for family relationships and communication.

## (3) The impact of lockdown on relationships and communication

Many people said that the lockdown has "extremely affected" their ability to communicate with others. The increased restrictions on movement particularly affect people who have no phone and rely on in-person visits with family. Internet access has been restricted in the camps since September 2019; movement and communication restrictions thus create an additional layer of difficulty for camp residents already coping with crisis and social isolation.

According to a 28-year-old man, without his **phone** he would be very isolated:

> I have relatives in different camps. I can't move freely there as before. One of my cousin-brothers is paralyzed. I visited him the first week of April but then it got hard to go since then, as there are checkpoints. But I can still call my relatives easily by phone.

Another young woman explained how important her phone was for her: “I dare not go to other camps to see my relatives but I can talk to them by phone.” A shopkeeper explained further that:

> I have some relatives in [other camps] far from here. It is quite difficult to go there as police checkpoints are in some locations. I contacted them by phone, but the network is not so good in the camp. If any emergency happens I have to see them, but I can't go there, particularly at night.

Many families have no phone access whatsoever, so **visiting relatives** in person is key for maintaining social connections. These families feel especially hard-hit by Covid-19. According to one older woman:

> Some relatives are in other camps. I don't want to go there as I am old. We are poor and we don't have a mobile phone. I can't contact them also.

Camp residents’ inability to be with their families during major events like **weddings, funerals, and religious festivals** is especially challenging. As one 80-year-old man said:

> One of my elder cousin-brothers…died on 10 June 2020. Many people and relatives could not come to his funeral as they were strictly prohibited from crossing the checkpoints. So they contacted his family anyhow, by phone.

People interviewed by the researchers had varying levels of awareness about the importance of **lockdown measures**, and the fact that they are global in scope. Some people stated their understanding and tolerance of increased security measures: one individual said, “I think security forces like the police and Army are doing well” by strictly enforcing the lockdown.” Others believe that the lockdown is focused on the camps, and this leads them to experience the restrictive measures as a form of injustice against Rohingya people. A 56-year-old grandmother complained about not being able to see her grandchildren in another camp, but she did not dare to travel there because her neighbours “told me I would be beaten by authorities if I tried to go there.” Without a phone, she worried about whether her family members were getting their rations on time, and if anyone was feeling unwell. From her perspective, it did not make sense that there would be no system for going to visit relatives. Several other respondents mentioned in interviews that the fear of being beaten by the authorities was a key reason for not leaving the camp.

There are also evident **mental health** repercussions to the lack of social contact. For many camp residents, especially men, going out to talk with friends at a tea shop is an important form of social support. A 23-year-old youth said:

> Sometimes when we were free, we could go for a hangout with friends and when we felt bad we could discuss our problems with friends to get relief, mentally. But now mental problems

> are increasing because we can't get any counseling from any friends. With the [phone/internet] network unavailable in the camp it's been more difficult to communicate with the people I trust and love.

One person pointed out the need for specific social support beyond general peer support:

> Suppose the father is staying in one camp, but his son is staying in another. If the father has a problem or gets in any trouble, he wants his son to help and stand by him. But now the son can't go to his father, as the vehicles and roads are closed.

Challenges also arise for polygamous families. A 38-year-old man with two wives and two sets of children explained that:

> I have two wives and two families. One family stays with me and the other stays far away. They have a lot of challenges but I can't solve them due to the lockdown restrictions. I have the responsibility to care for my second family, and I love them, but I can't go meet them.

However, for many people, lockdown conditions are reminiscent of the **movement restrictions** they have faced for years:

> Life is already a lockdown to us refugees before the Coronavirus affected the camps. We have no internet access, we are not allowed to go out of the camps, and we have no good mobile phone connection… This is forcing us to go back to Myanmar. I think communication is very important for anyone to get any information, but we cannot taste it here.

An additional problem that has materialized in connection with Covid-19 is that there are widespread concerns amongst community members that medical clinics and hospitals are places to be avoided. The following section identifies the fears and anxieties keep people from presenting at hospital when they experience symptoms of the virus.

## (4) Perceptions of medical clinic and hospitals

Camp residents have been reluctant to seek testing, isolation and treatment for Covid-like symptoms, and many fears and rumors have spread in the camps about ill treatment in isolation facilities. Reflecting on these dynamics, one older woman expressed a sort of **fatalism** about whether she would contract Covid-19:

> I myself sometimes want to go to the clinic, but I hear from women that if I go there, I will be tested and might be sent to a separate place. So I am worried about being alone, away from my husband. For the last week I have felt a little feverish and I'm coughing…[my husband got] some medicine for me from the pharmacy. This [seasonal illness] happens to me every year,

> not only this year. So why should I go there for a test? I believe in Allah. He is the only creator, and all the good and bad things are with his orders. So it's up to him.

However, some remarked that the **hesitation to seek treatment** from NGO-run clinics is not a new occurrence. One interviewee stated:

> People have not been going to NGO clinics and hospitals for a long time now. This is not a new thing. My mother went to a clinic several times. She waited for a long time and then returned without any medicine. The next time she went, she got some paracetamol and two other kinds of medicine. She has taken them but she has not recovered. So, we are not crazy about going there as we don't feel comfortable. These days, people are mostly worrying that they will be sent to an isolation centre.

This worry is due not only to fear of being separated from loved ones, but of being **poorly treated** at the clinics such as those run by HOPE (a national NGO) and BRAC (a Bangladesh-based international NGO):

> It is well known that the staff are dealing with refugees in a bad manner. They don't show respect to us. We don’t feel good for this reason. The staff also play games and talk to their friends with mobile phones while patients are waiting. This is disrespectful of us and wastes our valuable time…So we buy medicine from outside.

Coming back to livelihoods issues, some worried about not being able to work if they were to be **isolated**. Others feared being essentially imprisoned in the facility or sent to Bhasan Char if found to be infected. One person suggested that medical NGO staff invented Covid-19, describing diagnoses of the virus as ‘fake news’ circulated by those running the clinics. This individual also thought that patients would be mistreated in the clinics, and even physically harmed by the doctors – for example, that patients are slapped if they make noise. Especially troubling is the rumor that those infected will actually be killed by doctors. Even those individuals who personally had no bad experiences in camp clinics believed these rumors might be true.

Another reason that camp residents are not seeking treatment at the clinics is that they have heard there is **no cure** for Covid-19, so any help they could receive at the clinic would be limited. The primary purpose of the isolation facilities is for mitigating the spread of the virus, rather than treating those who have actually contracted it. An awareness of this leads people to assume that, even if they do not have Covid-19, they will be kept in isolation and away from their families. For the same reasons, they worried that if a family member were to be put in isolation, they could not see them.

In this context, treatment from unqualified pharmacists—referred to often as ‘**community doctors**’, ‘illegal doctors’ or ‘quack doctors’—becomes an appealing avenue. Camp residents buy medicine with their own money (if they have any) from pharmacies and seek the treatment of

community doctors who are not licensed to practice medicine. One individual explains that the latter are helpful because they 'communicate with people smoothly, and patients can explain their symptoms to them freely and clearly.' Community members were often aware that these doctors are unqualified or unlicensed, but it was also understood that access to formal training at home in Myanmar was limited for Rohingya. Some camp residents expressed the wish that these community doctors would be more integrated into the healthy system overseen by humanitarian agencies in Cox's Bazar. As it stands, the doctors operate in a "shadow" health system and seek to avoid detection by the authorities. Further information about the community doctors will be shared in the final report for this project.

All of the above beliefs and perceptions suggest that more is needed in terms of messaging about Covid-19 in the camps, and the dissemination of accurate, reliable information about the clinics. The next section of the report expands on this finding to examine the messages that camp residents would like to pass on to humanitarian agencies and other actors active in the camps.

## (5) Concerns to share with humanitarian agencies and other actors responding to the pandemic

Across the conversations held with community members about Covid-19 experiences, many expressed the wish for improved communication with humanitarian agencies and other actors working to improve life in the camps. Many people felt that NGOs were not responsive to their ongoing issues with livelihoods, with the quantity and quality of rations available, as well as more general difficulties such as the decline of religious life and general services in the camps during lockdown. Respondents wanted humanitarian agencies to reopen learning centers and expand formal education opportunities, give shelter improvement materials, distribute more LPG [liquefied petroleum gas] and increased rations, repair and improve tube wells, and help residents maintain better cleanliness of the camp environment.

As noted in Section 1 of this report, many people interviewed voiced requests pertaining directly to dealing with Covid-19, asking for **masks, soap, gloves**, improved health facilities, and more information about the virus. It was repeatedly conveyed that megaphone messaging was not doing enough to address the fears, rumours and misperceptions that are circulating in the camps with respect to Covid-19.

One person described their family's plan to provide **home-based care** in case anyone in the household contracts the virus, and said that some supplies are needed to do this effectively:

> If any of my family is infected, we do not have enough space to keep the infected one separate from those who are not infected, as you can see in my small shelter. For us, to keep the patient

separately, we will need some items to be used separately for the patient. We need different food, clothes and space for them. We should get medicine and awareness regarding Coronavirus in order to be able to protect ourselves from its spread. I think we will be able to keep ourselves safe if these things are given to us. I also think it will be better for us to try to protect ourselves on our own.

One of the complaints voiced frequently in regard to humanitarian agencies responding to the pandemic is that **some staff do not practice physical distancing or wear face masks**. Respondents thought that aid agencies might even be bringing Covid-19 to the camps, and said they would feel safer with better precautions in place:

> Now, I can see the staff at the distribution points are sometimes without masks and not maintaining social distance. We are afraid of someone coming to camp and we don't know if he/she has Coronavirus or not. Let them obey the rule first. In camp, people didn't have Coronavirus but I believe because of such kind of staff, now we face Coronavirus disease in camp.

Another person shared that NGOs did have proper gear to protect themselves from Covid-19, but that **they were not helping community members mitigate the spread**:

> There are many agencies and NGOs working around the camps. None of them has yet provided anything regarding Coronavirus. Once, some Rohingya youths from a civil society group came to our block and provided some masks. Except for those masks provided by Rohingya youth, I heard that no other things regarding coronavirus have been given anywhere by any NGOs. We see many NGO staff coming here [in protective gear]. But we don't have such preventative things.

Another challenge that community members are facing is **crime and corruption** in the camps, and they wanted NGOs and government agencies to know about practices such as police levying fines against individuals who opened their shops. One individual describes this practice as a form of extortion:

> Sometimes people gather on the road and watch the police arrest the shopkeepers and put them in their cars. I heard people give 5000 taka each to the police when this happens. Then they open their shop again the next day. I don't like how the police are extorting money from our Rohingya brothers, our shopkeepers.

At the same time, this individual wanted the police to play more of a role in the camps to ensure security. He described a scenario where a shop was held up by armed locals wearing face coverings, and wished that NGOs and government security actors would do more to prevent such occurrences.

Some community members expressed the desire to be more included in humanitarian affairs, sharing that they felt **locked out of decision-making** that affected life in the camps. It was clear from the interviews conducted that, beyond the issue of awareness of Covid-19, there is a lack of trust and open communication between camp residents and humanitarian agencies. One moulana emphasized how religious leaders could be a bridge for NGOs to link to the community: "I personally suggest NGOs to work closely with Moulanas from different camps and take our views and ideas into account. Include us for any meeting or training. We should not be excluded. Our people anyhow listen to us and follow us on what we guide them." Meanwhile, others looked beyond the camps and expressed their ultimate request of returning home to Myanmar: "We want to go back as soon as possible with our rights."