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COMMUNITY VIEWS ON THE IMPACT OF COVID-19 IN ROHINGYA CAMPS

*A report compiled by community researchers in Cox's Bazar,
Bangladesh, for the Political Settlements Research Programme
(PSRP) at the University of Edinburgh*



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 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 68 interviews with camp residents, the study examines five dimensions of Rohingya experiences of the pandemic. This report is a follow-up study to the 'Flash Report' released in July 2020, focusing on a second round of 34 interviews conducted in Cox's Bazar.

(1) Awareness and understanding of Covid-19

As of July 2020 many camp residents have a fairly basic understanding of Covid-19, but they are still lacking detailed and accurate information on the specific actions they can take to protect themselves and their families. In the earlier 'Flash Report' it was noted that some respondents suggested that door-to-door information campaigns are needed in order to correct rumours and misunderstandings, and this request was again voiced in the more recent round of interviews. 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. This is despite recent attempts by international agencies to increase the distribution of masks and other essential items. In the latest round of interviews, there was a discernible rise in the number of respondents who voiced disbelief that Covid-19 exists in the camps. Individuals who made this point doubted that the lockdown measures in place are truly necessary and drew attention to all the ways that camp life was made more difficult by the lockdown measures.

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

It was shown in the earlier 'Flash Report' that 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 because of social distancing, orders from the authorities to close and a lack of

customers due to lockdown-associated movement restrictions. 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. In the more recent round of interviews, this trend continued as many respondents said that economic harm was the most serious form of harm they had suffered in connection with Covid-19. The global pandemic is having a serious impact on remittances and other forms of support from family members located outside Cox's Bazar as well.

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

In the latest round of interviews, almost every respondent struggled to maintain family relationships and communication with loved ones during lockdown. Grandparents missed the birth of grandchildren, and spouses couldn't give their departed spouse a proper funeral. While some of these challenges mirrored those that have been experienced by the global community since the onset of Covid-19, Rohingya camp residents experienced these restrictions in a different way because, for them, living in camps away from their home country was already a constrained and restricted way of life. Camp residents explained that they not only had difficulty reaching family members in other camps in Cox's Bazar, but also in keeping in touch with family members who had gone to clinics, been put into isolation, or sent to Bhasan Char.

(4) Perceptions of medical clinics and hospitals

Since the onset of Covid-19 in Cox's Bazar, testing, isolation and treatment for Covid-like symptoms in the health clinics and hospitals have not been appealing options for camp residents. As internet access continued to be restricted and verifiable news in short supply, rumours about treatment in the official health clinics spread through the camps by word of mouth, leaving many to keep their distance. 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 continues to pose an obstacle for attempts to stop the spread of the virus and to treat those who contract it; this has opened considerable space for the operations of unlicensed health practitioners, sometimes referred to by community

members as "community doctors". Interviews conducted with several unauthorized practitioners revealed that some of them doubt the severity of Covid-19, questioning the existence of the virus even after the first cases had already been officially recorded. Despite their lack of formal qualifications, camp residents continue to seek out these unauthorized health practitioners for health advice and treatment amidst the pandemic.

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

In the latest round of interviews, community members emphasized the desire to return home to Myanmar. Many remained critical of the practices of some NGO workers in the camps. Some humanitarians continued to fail to wear masks all of the time, and a more general concern was that in light of the draw-down of humanitarian services INGOs and other humanitarians were simply less present in the camps. As found in the 'Flash Report', community members sincerely desire more meaningful engagement with humanitarian agencies and international actors whose decision-making impacts life in the camps. In the absence of strong two-way communication, they continue to feel that things are happening to them without their input or control. Several respondents also accused NGOs of focusing more on taking photographs for donors, or putting up banners and posters about Covid-19, instead of providing meaningful help. All of this could have serious implications for how community attitudes evolve with respect to lockdown measures and Covid-19-related advice disseminated in the coming months.

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INTRODUCTION

As the majority of displaced people living in the Rohingya refugee camps in Bangladesh enter their fourth year of displacement after arriving in 2017, the ongoing challenges of camp life have been compounded by the looming threat of Covid-19. Due to restrictions on internet service and the drawing down of humanitarian access as a result of lockdowns to prevent the spread of the virus, community engagement has been made more difficult during this time. This means that opportunities to adequately consult community members' views, priorities and needs during the pandemic are scarce.

As of mid-August 2020, only 79 cases of Covid-19 had been formally confirmed in Cox's Bazar, with 6 reported Rohingya [fatalities](#)^[1] from Covid-19. The low figures may be attributable to low testing rates and possible under-reporting, a claim which is supported by higher reported rates of transmission in the host community: there were 3,678 reported host community cases and 61 fatalities over the [same](#)^[2] reporting period.

This [study](#)^[3], *Community Views on the Impact of Covid-19 in Rohingya Camps*, aims to gather community perspectives from diverse people on the impacts of Covid-19 in the camps, including those of youth, elders, women, people with disabilities, religious leaders, people with relatives living on Bhasan Char, and recovered Covid-19 patients. The perspectives of several unlicensed health practitioners are also included. Known as "community doctors" or "quack doctors," they provide medical services to camp residents outside of the formal camp health system run by humanitarian agencies.

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 centered local researchers who live in the camps of Cox's Bazar. Two of the three camp-based researchers who led the project are youth. Together, they scoped the research project, developed a series of research questions based on their assessment of community needs, and conducted 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 identities of all respondents who were interviewed have been anonymized.

The study contributes to the goals of the global agenda set forth by [UN Security Council Resolution 2250](#) on Youth, Peace and Security. This international framework, which is the first of its kind, signals an appreciation of the important role that young people potentially play in peacebuilding, preventing and resolving conflict, and countering violent extremism. The study supports these aims on a substantive level by canvassing

youth perspectives on justice and security in the world's largest refugee camp: Cox's Bazar, Bangladesh.

Topics of Inquiry

During the initial planning phase in early 2020, the original research question that propelled the research project was: how do youth (males and females ages 18-29), understand issues of justice and security in Cox's Bazar, and what role they play in fostering peace and justice? With the onset of Covid-19, the project was updated to canvass community perceptions about the disease, and the additional challenges and needs that have arisen for camp residents during the Covid-19 response in the camps. Building on earlier conversations about life in the camps, the community-based research team developed their own set of questions to investigate, focusing specifically on community experiences during Covid-19. Based on the issues that they deemed important to their community at the time, the seven questions the researchers ultimately selected to pursue are as follows:

1. What knowledge and ideas do you have regarding Covid-19?
2. Has the lockdown of Covid-19 affected your livelihood? If yes, how?
3. Has the lockdown of Covid-19 affected your relationship and communication with others? If yes, how?
4. What would you want from humanitarians and agencies as assistance to help you to prevent the spread of Covid-19?
5. Since the lockdown of Covid-19, what are the most difficult things you have faced that you want government and humanitarian agencies to know?
6. Why are people worried and afraid of going to the clinics or hospitals since the appearance of Covid-19?
7. Do you have any questions or anything else that you want to share with us?

The report groups together 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.

Methodology

The study espouses an emancipatory approach that centres youth agency and draws on best practices in the field of ‘participatory action research’. Rather than serve as local enumerators for an international project, the researchers developed the research questions themselves, and built the project in accordance with their own vision for their community with support from academic researchers.

This participatory research project empowers young people residing in Cox’s Bazar to interview their fellow youth as well as adults and elders in their community. The model builds on Dr. Rebecca Sutton’s visit to Cox’s Bazar in July 2019, where she delivered intensive training to members of the ‘Rohingya Youth for Legal Action’ (RYLA) organization, focusing on participatory action research. For [more information](#)^[4] on that training exercise, see ‘Field Note: Knowledge Exchange in Rohingya Camps in Cox’s Bazar’.

Participants in the project

Researchers

Three dedicated community-based researchers supported the project. The main (adult) researcher guided two youth researchers to engage in community-based research and report their research findings to international donors and civil society organizations in Cox’s Bazar. The three reported to, and were supported by, a small team of three international research coaches. The remote support team assisted the main researchers to identify appropriate participants and to develop selection criteria for community interviews. All research activity took place within the Cox’s Bazar camps in Bangladesh. The research coaching team comprised Imrul Islam, a graduate student of Conflict Resolution at Georgetown University who is originally from Bangladesh; Jessica Olney, an independent research consultant; and Dr. Rebecca Sutton, from Edinburgh Law School.

Respondents

Responses were collected throughout the months of May, June, and July 2020. This report draws on overall findings from the larger project (which includes 68 interviews in

total), but it concentrates on findings that have arisen in the 34 interviews conducted after the first 'Flash Report' released in July 2020. Of the interviews conducted in the second round of research, 11 respondents were female, 23 were male, 4 were religious leaders, 5 were unauthorized health practitioners,^[5] and 17 were youth. One respondent was a person with a disability (deafness), and one was a recovered Covid-19 patient.

Covid-19 safe data collection details

Due to the dangers presented by Covid-19, the highest priority during the interview process was to keep the local researchers safe and compliant with health guidelines. They conducted phone interviews and other socially-distanced forms of information gathering. As of June 2020, researchers were conducting one-on-one and small group interviews in a socially distanced manner while wearing masks, and continued to interview some people by phone. When the local research team gathered in person to discuss findings, they remained socially distanced and wore masks, and also followed hygienic procedures such as hand washing. Otherwise, they communicated by phone when travel across the different camps in Cox's Bazar was not feasible due to shelter-in-place guidelines.

DETAILED FINDINGS

The community-based researchers compiled a variety of views from Rohingya community members regarding their perspectives on Covid-19 and the response to prevent its spread in the camps. The findings presented here point to the heterogeneity of views amongst diverse community members and highlight the importance of avoiding generalizations, though key trends have been highlighted where appropriate.

(1) Knowledge, understanding and perspectives of Coronavirus

By the time the second round of research was conducted, most of the people interviewed had an understanding of the main symptoms of Covid-19. They were aware that the elderly and those with preexisting conditions are at the most risk, and were familiar with common prevention measures including wearing masks, social distancing, hygiene, hand-washing, and sheltering in place. However, many expressed wanting more detailed information about the nature of the virus and prevention. An unlicensed health practitioner living in Camp 13 listed preventative measures that had gained widespread acceptance within the camps:

People should stay home, maintain social distance, avoid handshaking, avoid kissing, and wash hands for at least 20 seconds. This should be done frequently with antibacterial hand soap and followed by rubbing hands with hand sanitizer. People should wear hand gloves, face masks, and protective glasses. **They should stay home**, avoid going to crowded places like child-friendly spaces, mosques, religious schools, government schools, and wedding ceremonies. The symptoms are high fever, coughing, sneezing, body pain and loss of energy. According to my understanding, there is a very high risk for people over 60 years of age, and for those who have been suffering diabetes, blood pressure, typhoid, etc.

While many reported having substantive knowledge of Covid-19 and its prevention, as has been the case in other global (displacement) contexts, conspiracy theories and doubts about the virus and its prevention still exist within the camps. Due to the virus' low impact on the Rohingya population thus far, some have come to doubt the fact that it actually exists. For instance, according to a 27-year-old NGO volunteer living in Camp 1W:

Our people named this virus as the “death virus” because it causes death to whoever is infected. As soon as the coronavirus appeared here, people

overreacted and talked about it so much, but it is clear now that it is nothing to worry about. For me, it is clear that there is no truth to the Coronavirus despite whatever has been said about its arrival in Bangladesh. We don't actually see Coronavirus here. We have not been maintaining any social distance or other preventative methods.

Here, some people who use masks exchange and rewear them in order to be safe from the security forces, not from the virus. No one washes their hands once or twice a day with any intention of preventing the virus. Even though the people are not cognitively aware of its infection and dangers, nothing severe has appeared in the camps. Perhaps the Coronavirus infected here, but it did not bring us any harm or cause anyone to die. ... It seems to me like the virus was invented just to divert people's attention to it. It was clearly created as a way to threaten the people, nothing else.

Some camp residents, including an unlicensed health practitioner living in Camp 16, believe the virus to be real, but expressed misunderstandings about its nature. According to the respondent, Covid-19 resulted from influenza-related complications:

Regarding Coronavirus, it is a deadly virus that people should avoid. In camp, there has been no confirmed Coronavirus case, but there is a disease namely influenza. Influenza can cause Coronavirus by bleeding. The symptoms of influenza include having a fever of more than 100 F, whole body pain, and then after 14 days, it can cause cough and affects the glands on the side of the neck. After infecting the glands, if the respective person is not taking treatment, finally the normal influenza case progresses to become "bleeding influenza." From bleeding influenza, it is easy for someone to come down with Coronavirus. Coronavirus means having a high fever of more than 100 F, body pain, cough, neck pain, weakness and headache. To prevent Coronavirus, we have to stay away from previously infected persons and those who have Hepatitis C, diabetes, and high blood pressure.

It should be emphasized that this unlicensed practitioner is in the position of actively providing medical advice and treatment to possible Covid-19 patients. Given this, there is evidently still a need for better, more clear and concrete, information about the virus to be shared with camp residents. A challenge that arises in this respect is the fact that unlicensed health practitioners tend to operate in the shadows and outside of formal regulations. The situation of these doctors will be examined more detail in Section 4 below ('Perceptions of Medical Clinics and Hospitals').

(2) The impact of Covid-19 on livelihoods

It was mentioned earlier in the report that figures of actual infections and deaths related to Covid-19 in Cox's Bazar camps are relatively low (79 Rohingya cases and 6 deaths as of mid-August 2020). The economic impact of the virus, however, has been dire. According to a male youth, 19 years old and living in Camp 1E, his family has started selling a portion of their food rations to make ends meet. Such practices threaten to harm camp families' food security and access to nutrition:

I am doing nothing for my **family's livelihood**. My elder brother used to work as a mason and earned 10,000 to 13,000 taka for our family every month, which was more than enough for us. I just have to give 500 taka every month to my teachers at the madrassa. Now, my brother gets only a few days of work per month, from which he is only earning 5,000 to 7,000 monthly. So his earnings have been reduced by half due to the lockdown. We still get timely **rations** from WFP and sometimes, my mother sells 10kg to 15kg rice, potato and other items from our rations in order to cover my schooling fees. Covid-19 is affecting my family's livelihood. We have no other income sources besides my brother.

According to one elder, his life did not change significantly due to the lockdown, but he recognized the challenges faced by the younger generation of family breadwinners:

As I am an elderly person, I don't move around to other places much like others. I just stay inside my home all the time. I don't personally have any big difficulties due to the lockdown, because I think the lockdown is a good way to help us prevent the spread of Coronavirus. But I see that **there are big difficulties for those who are daily laborers**. I see them suffering without enough food because of not having the same income as before the lockdown. It is the only difficulty I see: that people can no longer go to other places to work and make a little money, with which they can buy some items. Now, they have no chance to work.

A 54-year old woman in Camp 16 shared her own experiences with selling rations to mitigate the economic impacts of the pandemic:

We are six family members in the camp. My husband has been jailed in Myanmar since 2016. In the camp, my oldest children are females. So they can't work according to our religious rules. Also, I am an older person and I face a lot of difficulties. Since lockdown I have begun **selling some rations**, such as blankets

beans, oil and so on. But that still does not earn us enough. I frequently face difficulties in providing meals. My children are demanding fish, beef and fruits, but I can't treat them. No one helps me with going to the market or buying medicines, and **I feel helpless.**

At times, Covid-19 has affected the livelihood of patients who stay in quarantine/isolation centres, by rendering them unable to provide for their families or seek humanitarian assistance. This is particularly a problem in times of greater need: monsoon season, for example, often causes shelter damage. According to a 45-year-old laborer living in Camp 1W, who stayed in an isolation centre during his bout with the virus:

No one else in my shelter does any business activities; **I am the only one doing something for my family** and I have been struggling to earn money as a daily laborer. During the days I was in the isolation centre, there was heavy rain with strong wind that destroyed my shelter. I went to the Camp in Charge's (CiC) office in Camp 1W three times, requesting shelter materials. But I still did not get any support. **What shall I do?** I don't have any income right now.

Camp marketplaces and the vendors that work in them have been particularly affected by the economic impacts of the pandemic. A 42-year-old shopkeeper in Camp 2W explained that:

The virus has caused big changes in my livelihood. I was in a good situation before, earning money by selling textiles in a shop in the Lambashia Bazar of Kutupalong camp. My daily earnings were 5,000 to 8,000 taka, from which I got an average of 800 to 1200 taka as profit. Now, it has totally decreased due to Coronavirus. I now only earn 300 taka per day by selling items at my shop. **I can't help my relatives now - it is even not enough for my family.**

A 35-year-old housewife in Camp 1E explained the impacts of Covid-19 on her family's ability to eat a balanced diet:

Yes, of course Covid-19 impacts our livelihood. Since the virus appeared in the camps, neither have we bought any nonessential items to consume, nor seen a single penny of income. **My family is just surviving off the rations** given by NGOs, as my husband can't find any work now. Before the lockdown, my husband could work somehow, so we could eat meat and fish. But now it seems impossible to buy meat or fish.

As a large numbers of Rohingya refugees face serious economic challenges, and struggle to survive, feed and take care of themselves and their families, lockdown is also impacting camp residents' ability to have meaningful communication with friends, family and relatives across the camps and beyond Cox's Bazar.

(3) The impact of lockdown on relationships and communication

The movement restrictions imposed by lockdown have impeded regular communication between camp residents. As time passes, this lack of connection presents an increasingly serious challenge for maintaining family relationships. The frustrations lockdown causes in this respect are compounded by previous internet restrictions that were already in place in Cox's Bazar: camp residents had already found it difficult to contact their relatives in other countries, and now they struggle to connect across different (parts of the) camps as well. As reported in the earlier 'Flash Report', many Rohingya refugees living in camps in Cox's Bazar feel that their life was already in lockdown, even prior to the onset of Covid-19.

A 28-year-old female NGO volunteer explains how the movement restrictions are reminiscent of those faced by Rohingya in Myanmar:

When we were in Myanmar, we Rohingya **didn't have freedom of movement or the right to education, health care, etc. Here in the camps, we are feeling the same things.** During Covid-19 life is more restricted for us. Our relationships are totally breaking down and our communication with relatives and friends has been cut off.

A 40-year-old man in Camp 1E echoed this concern, and coming back to the issue of livelihoods, also described the economic impact of the virus on his family's access to a remittance:

Before Covid-19, people could move freely within most camp areas, but during these times we are told that **people should not go far** due to the lockdown. I still visit the Modushara area of the camps, Camps 4 and 5, to see my relatives there. But currently I cannot go to Camps 15 and 18, where my other relatives are. It is restricted. My younger brother is in Malaysia. He sent us money last year. This year he cannot as he has no job there and we are hearing that the **Malaysian government is not as sympathetic to Rohingya as before.**

A man in Camp 16 also linked restrictions on movement to family communication and livelihoods:

Before we could communicate with our relatives in other areas properly, but since the lockdown most people have been facing difficulty to support their family because **they can't earn money** and can't go to the fields to do work. And **NGOs cannot come into the camps like before...** We cannot move anywhere like before."

A 54-year-old woman in Camp 16 shared her family's story of separation and great difficulty due to the lockdown.

My family has six members. Two of them are grown up; they are girls. One of them got engaged with a Rohingya person in Malaysia. There was a mutual process between the bride and bridegroom in order to bring her to Malaysia. Both families negotiated with a trafficker. One day, I went to the clinic and the girl was brought by a trafficker to Malaysia without my knowledge or consent. My daughter asked her younger sister, "Please talk to mother and tell her to pray for me because I am going to Malaysia without her consent." When I came home I called the trafficker and was told that he would deliver her to Malaysia soon. While she was in the hands of the trafficker, I struggled to go there and see my daughter. But I could not go because of lockdown. After three days, the trafficker told me that the girl had already boarded a boat. For two months we didn't get any information about our daughter.

After two months, she called and explained that she had reached Malaysia, but the Malaysian government hadn't allowed her to enter due to Coronavirus concerns. The boat was instructed to go back from where they came. When it returned and reached Cox's Bazar beach, she told me that she was in the hands of the [Bangladesh] Navy and talking with me using the Navy's phone. The Bangladeshi government also didn't allow the boat people to enter the camp. They were brought to Chittagong and told that they would be given a Coronavirus test.

The people on the boat asked the Navy why the boat seemed to be traveling such a long way, given that Chittagong is quite close to Cox's Bazar. That is when they were told that the Navy intended to transport them to Bhasan Char. Once there, my daughter was able to call and told me that she didn't feel comfortable there. She didn't get proper respect. After a few days, the government came to our home and collected our address, telling us that they would bring back my daughter. But now we are hearing that the government's

plan is to bring all family members to Bhasan Char.

Due to lack of network, I could not even talk for one minute with my daughter. My husband is in prison in Myanmar, my daughter is in Bhasan Char, and the rest of us are here in the camp. So, the lockdown due to Coronavirus and the lack of internet access have greatly affected our relationships and communication with our family members.

A 50-year-old man in Camp 15 reported that he missed meeting his new grandchild due to the lockdown:

When my **daughter gave birth** at home in another camp, she and her husband were unable to share the news with us at first, due to the internet access problems. After we got the news, we **could not visit** them due to the movement restrictions. Also, we weren't able to financially support them during this time, because we are no longer earning any money.

A 62-year-old man living in Camp 16 who has three children living abroad explained that long-distance communication has also become more challenging:

It is difficult to communicate with my sons due to the weak internet access. I have two kids in Saudi Arabia and another one in Malaysia. I used to get financial support from them easily but now, I can't move freely and also, they can't transfer money. They have been earning less money during the lockdown period, therefore I face a lot of difficulties. **It is very difficult to get support from those who are out of the country**, and communication is very limited by phone. Before, I communicated to all my sons by IMO and WhatsApp. Now, it's not possible to use those apps due to **lack of internet access**.

A 54-year-old woman in Camp 16 whose husband passed away during the lockdown shared that she was unable to arrange his funeral:

When my husband died, we had **difficulty informing my relatives** due to the lockdown and lack of internet access. Before my husband died, he tried hard to go visit his relatives and villagers, but couldn't because of the lockdown. Right now my mother is really sick in another camp, and I want to visit her there, but I can't.

A 25-year-old NGO volunteer, Camp 1W also complained about the social impacts of the lockdown:

Now, **we can't even attend funerals** of our close relatives. The sons or daughters can't visit their parents. We can't meet friends and relatives now which we could do before the lockdown. We can't call our relatives from different camps to have consultations together on marriage or other important and ritual matters which is like our culture.

A 23-year-old man in Camp 1E explained that people are forced to travel “by foot, secretly” if they must go to another camp, as roads were closed down due to the lockdown.

While some of the challenges described above have been felt globally in connection with the Covid-19 pandemic—such as inability to attend the birth of grandchildren or prepare proper funerals for the deceased—Rohingya refugees living in Cox’s Bazar camps are especially hard hit by the severed connections between families and with relatives abroad. For those living in the camps, lockdown further deprives them of family networks and support systems that were already under strain before the pandemic.

(4) Perceptions of medical clinic and hospitals

As they navigate the fear and confusion wrought by the pandemic, camp residents report trepidation around receiving medical care from camp health clinics in Cox’s Bazar. The medical personnel of these clinics are staffed entirely by non-Rohingya, mainly Bangladeshi staff. As noted in the earlier ‘Flash Report’, Rohingya community members recounted hearing rumors that led them to fear being forcibly tested for COVID-19 at clinics and then involuntarily placed in isolation away from their families. As the ‘Flash Report’ further noted, there are even rumors that patients could be killed, or that the bodies of deceased Covid-19 patients will be withheld from family members. These rumors compound the mistrust that camp residents already felt toward health clinics, and fueled community perceptions that health infrastructure in the camps is weak overall.

A common complaint heard in the camps prior to the pandemic is that clinics “just provide Paracetamol for every disease.” This perception has continued since the onset of Covid-19, contributing to generally low expectations of camp residents

getting appropriate help from clinics. A male youth further remarked that patients arrive at clinics “from all different locations” and that the clinics are thus seen as a potential disease vector. Others cited the long waiting times as a reason for declining to visit clinics and hospitals during the pandemic. Apprehensions of bias and ill treatment also led Rohingya community members to avoid clinics. Some reported that clinic staff “hate” Rohingya people, while others mentioned feeling “disrespect” and “discrimination” from clinic staff.

Across the dozens of interviews conducted for this study, these perspectives seem quite widespread – including amongst camp residents who have never visited the clinics themselves. This is a sign of how much communication travels by word of mouth in the camps. The internet ban is again relevant here, as it means that rumours can spread more readily than verifiable news. While reliable empirical data is not yet available to quantitatively assess patient satisfaction with camp health facilities, the local research team documented similar complaints in nearly every interview they conducted. In a rumor-mill context it is easy to see how a small number of people’s bad experiences at clinics could shape the overall community’s negative perceptions.

In contrast to their attitudes to the formal health clinics, many people prefer to visit unlicensed health practitioners and informal pharmacy shops. As noted in the ‘Flash Report’, a 53-year old religious leader said of the clinics that “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 because of this, and also they are playing games and talking to their friends by mobile phone while patients are waiting.” For such reasons, community members often opt to seek advice and supplies from informal sources outside of the clinics.

Unlicensed health practitioners in the camps offer an appealing avenue of recourse for camp residents who fear going to clinics. However, as will now be examined in more detail, the practices of these practitioners present some further complications. Camp residents in Cox’s Bazar use the terms “community doctor” “fake doctor” “illegal doctor” and “quack doctor” to refer to Rohingya who have set up pharmaceutical shops in camp markets or their shelters and who offer services as unauthorized health practitioners. As a 23-year-old woman described:

People usually buy medicine from the pharmacy. Those who have no income simply rely on Allah. In the camps, most people go to “community doctors” because people trust them more. Community doctors communicate with people smoothly, and **patients can explain their symptoms to them freely and clearly.**

While many in the community seek treatment from these persons, others are aware that they are working illegally and providing medications without proper training. However, these unauthorized practitioners are often educated members of the community who consider themselves to be learned on matters of science and health; in many cases they would have pursued formal training, if they had been given the right to access health-related professions in Myanmar. Some of these practitioners also voiced a request to be integrated into the formal humanitarian health system in Cox's Bazar.

The researcher team spoke with several unlicensed health practitioners to learn their perspectives on Covid-19. One individual running an informal pharmacy shop in the camps stated:

There are some differences between bacteria and viruses. I studied some books and I have knowledge about it. Viruses are more serious than bacteria. Right now **we are hearing about Coronavirus** affecting people everywhere in the world. ... In Bangladesh, we hear the affected persons are increasing day by day. In Cox's Bazar district, almost all the wards are [in] lockdown. It is more strict now as we hear from staff members coming to camp. I think our people don't have much knowledge about it. The patients who come to my pharmacy shop have been advised to stay safe, to wash their hands properly with soap and not to go outside unless it is important.

A 31-year-old community health practitioner noted the community's fears about the virus but believed that the community had thus far been spared from its effects. Speaking as the very first signs of Covid-19 were appearing in Cox's Bazar, he said:

It is being said that the Coronavirus is a virus which is spreading all over the world so rapidly. So, it is very important for every one of us to stay safe from its spread, as it is a contagious disease. **It has not appeared in our camps yet** with the mercy of Allah. We haven't yet witnessed the Coronavirus and its dangers here, but we hear that it is infecting other places in the world. We get very worried here when we think about the appearance of Coronavirus here in the camps.

Fortunately, **Allah is keeping us safe** from the spread of Coronavirus so far. The people in the camps who have heard and have knowledge about the virus, they are very worried and panicked. But those who don't have

any idea or information about it are unaware and not tense about it...Some people don't worry about the Coronavirus who don't have any information about it, and they just believe in Allah's will for anything that happens.

People are **very crowded in the camps**, and some use masks whereas some don't. Some don't maintain social distance and they just go to gatherings without anxiety as they haven't learnt about the Coronavirus. Even with all these unaware acts that could enable the spread of Coronavirus, the virus has still not appeared here.

A young unlicensed health practitioner, 22 years old, reported that a regular seasonal flu had been spreading in the camps, and was confident that the recent illness was not due to Covid-19. His view was echoed by many residents in the camp, who observed that the illness must have been a flu as most people quickly recovered without complication; they also noted that the illness spread after a week of flooding and heavy rain in mid-June 2020. He proposed:

People get diseases during the changes of climates and weather every year. These types of diseases have been named as coronavirus in the camps, but there are not actually. **The Coronavirus is another disease.** It is not appearing in the camps now, but it is true that it is infecting other parts of the world. The government and agencies are taking and moving people in the camps by doing tests and checks and then labeling their condition as Coronavirus. In fact, this is not Coronavirus that is spreading in the camps. ... People get mild fever, cough and body aches, which are appearing due to the changes of the weather. **Any doctor can provide treatment** for these mild diseases. For these diseases, it takes patients five or seven days to become recovered by taking proper medicines. There are some sorts of medicines manufactured by famous and quality factories for these common diseases, but the medicines with different items should be given depending on states and ages of the patients. If the patients with these diseases take the medicines for seven days properly, **the disease gets cured.** These diseases appear every year.

This same practitioner shared that he was much more concerned with Hepatitis C, which he estimated to be affecting the camps at a rate of 25-40 percent of the patients (ranging from 25 to 60 years of age) who visited him. He requested the international actors working in Cox's Bazar to explain why there is not more concern about the non-Covid-19 diseases affecting camp residents. Even though

the first Covid-19 case had appeared in the camp one month before this community doctor was interviewed, he shared his belief that no unlicensed health practitioner in the camps had yet had a Covid-19 patient.

Speaking also in the early days of lockdown, one of the unlicensed health practitioners expressed his support of the lockdown measures taken by the government:

I am very thankful to the government for setting up the lockdown which is making people immobile. It is very important and **good for people to have this lockdown** in order to be safe from the Coronavirus, and the Coronavirus has not appeared in the camps yet. The government has only set up this lockdown in the camps to keep people safe during the Covid-19 pandemic. ...

I personally think the lockdown is very important in the camps because **people are living here like a colony of ants**. I don't have any negative feelings about the lockdown setup because I think it's a good thing to do here. Yes, I know it is affecting our communication and movement, but we have to go through this difficult situation. The shops and markets are closed due to the lockdown, but things are still available which are necessary to live...

Actually, the word lockdown is not new for us, as we were under lockdown when we were in Myanmar. **We have been facing a lockdown since our childhood**. So, the Coronavirus lockdown for us is the same as the way we used to live in Myanmar. ... The government still allows people to go to hospitals at any time for the treatment, so it's nothing too difficult for us. The lockdown is good for me. We have to follow the rules and regulations of the place where we live.

Despite lacking medical expertise, unlicensed health practitioners in Cox's Bazar typically gain community trust due to their "soft skills". One such practitioner was forthright about this and lamented his own lack of expertise:

I feel so bad because community doctors are not qualified enough to give proper treatment and we have no medical training or experience. Most are uneducated...Our Rohingya community trusts community doctors more than they trust Bangladeshi medical doctors. That is very bad. We should trust those who have medical licensure and expertise....Sometimes I can't

give treatment when patients have big problems that are unclear to me. When that happens I feel very very bad. One thing I want to add is that I use good communication, show empathy and take time to care for each of my patients.

As shown in the commentary above, unlicensed health practitioners may recognize their lack of formal medical qualification but tend to defend their practices on the basis that they are affordable and available to community members, who can trust them to listen. At the same time, these practitioners' perceptions of the spread of Covid-19 were often out of step with official statistics and reports on the virus.

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

As with the earlier 'Flash Report', many community members interviewed about Covid-19 mentioned their strong desire to return home to Myanmar as soon as possible. One man requested the government of Bangladesh to "make a bridge to cross the Naf river safely for us with a good solution." In the shorter term, one of the most frequent requests documented by the research team was for more open movement access within the camps. Many respondents also requested access to education, both religious and academic, as well as restored internet access to enable communication with relatives in Myanmar, overseas, and on Bhasan Char. Others made a general request for better healthcare services.

Most community members who were interviewed requested supplies that can help them protect themselves from Covid-19, including masks, soap and hand sanitizer. Some advised that isolation facilities should be available in each camp for the sake of greater accessibility and community trust. Others said that more handwashing stations are needed throughout the camps. Increased attention to waste management and latrine hygiene were also seen as important measures for improving camp health overall. Many people also requested increased outreach and awareness raising, particularly door-to-door by Rohingya volunteers, to educate people in the camps about the details of the virus. One unlicensed health practitioner participating in a focus group discussion (FGD) asked for NGOs to hire and train him and other such practitioners to enable their formal integration into the camp health system.

The same FGD participant stressed the need for more community engagement:

We want humanitarian agencies to help us prevent the spread of Coronavirus. We request humanitarian agencies to work for the betterment of our community by standing together with us. That means they should have to engage with our community and they should consult with us before doing anything. In the camps, there are so many Rohingya who are trained professionals. Humanitarians should hire them to work in their areas of expertise.

A religious leader in Camp 1E praised the work of some NGOs, but shared his doubts about the integrity of others in the context of a draw-down of humanitarian services:

Most organizations are doing well. But some NGOs are not doing well. They are working for only one or two days a week and **taking pictures to show their donors**. It is not good. We want to avoid them. I want to request that NGOs work honestly within their budgets.

A male youth, 19 years old, in Camp 1E voiced his concerns that humanitarian actors are not doing enough awareness raising in the camps about the threat of the virus:

NGOs should do more awareness raising and provide us with essential items to prevent the Coronavirus as there are over a million people in camps who need protection. According to my observation, more than half of these people, including myself, **still don't know the accurate information** about how we can keep ourselves safe.

A 40-year-old man who is hard of hearing requested a hearing aid from humanitarian actors. A 42-year-old man identified several challenges with NGOs:

They should provide effective awareness to people and educate them on good practices. They should provide necessary protective items. **Please don't show only banners and big posters about Covid-19**. All INGO workers should respect the guidelines of Covid-19 prevention. **Prevention is for them, too**, not only for camp people who should follow the rules when they go to distribution points. NGOs should also conduct very clear assessments to find out if people are being charged to receive their services by majhis [block captains] in some of the blocks.

Elders interviewed were aware that their age bracket faces higher risks of serious infection, and requested support from humanitarians for chronic conditions that leave them compromised. A 54-year-old woman shared the recent loss of her husband, a possible Covid-19 patient with preexisting conditions:

We need soap for hand washing, a dust bin for keeping tidy, face masks, hand lotion and hand gloves. At the beginning when we arrived in Bangladesh, my husband's leg was amputated because he suffered from cancer. He also suffered diabetes. After the lockdown we couldn't buy medicine from Cox's Bazar anymore due to the movement restrictions and our reduced income. After Coronavirus appeared in the camps my husband suffered from high fever, blood pressure and increased diabetes. After five days he passed away. So, I want to raise awareness everywhere about Coronavirus. **People need to know how we can avoid and treat it.**

A 62-year-old man shared his own concerns about the virus due to his age:

We definitely want assistance from humanitarian agencies to prevent the spread of Coronavirus. I am 62 years old and I am suffering from major diseases. **I am afraid**, because Coronavirus is a very dangerous virus. So I want to get help from any organization. I heard the disease immediately affects those who are more than 60 years old, so it is necessary for me to take very good care of myself.

Some young respondents voiced doubts about the existence of Covid-19 and wanted humanitarian and government actors to understand their frustrations about lockdown. One 27-year-old Rohingya NGO volunteer denied Covid-19 was present in the camps and voiced doubts that more support from NGOs could be useful:

We don't want any more assistance besides whatever we are receiving now. I don't think the Coronavirus will come here, and **I don't think the supposed cases in the camps are real** despite whatever is being said about it. I don't feel comfortable when I hear about this Coronavirus, so please don't ask me anything more about it. To me, talking about the Coronavirus is like speaking some sort of gibberish.

A male NGO volunteer, a 25 years old living in Camp 1W, lamented various impacts of the Covid-19 lockdown, and like many respondents, iterated that his overall concern is about whether displaced Rohingya will be able to repatriate back to Myanmar:

We just keep sitting within our respective blocks without seeing our relatives and friends in other camps. **Our shelters are about to fall down** by themselves as they have gotten very weak. These concerns are only because of the Coronavirus. But the most important thing is that we are not receiving updated news about our repatriation to Myanmar.

All of us are in a sorrowful situation with regard to repatriation. Whatever people receive as aid from NGOs really makes us grateful, but I always hear a voice from every single person's mouth asking about **repatriation**. ...I just want the international community to work on our repatriation and help us make it happen. **We want our repatriation more than we want the assistance we are receiving now**. This is my last request to you as well as to the international community, to know that every one of us here has the desire to raise our wish for repatriation at the international level. We rarely have the opportunity to share this.

NOTES

[1] Relief Web, 'Covid-19 and Monsoon Preparedness and Response for the Rohingya Refugee Camps and Host Communities in Cox's Bazar District Weekly Update #23, 7 to 13 August 2020'. Available at: <https://reliefweb.int/report/bangladesh/covid-19-and-monsoon-preparedness-and-response-rohingya-refugee-camps-and-host-3>

[2] Ibid.

[3] See also the July 2020 interim 'Flash Report': Rohingya Experiences of Covid-19 in Cox's Bazar Camps. Available at: <https://www.politicalsettlements.org/publications-database/rohingya-experiences-of-covid-19-in-coxs-bazar-camps/>

[4] Available at: <https://www.law.ed.ac.uk/research/impact-and-engagement/field-note-from-the-rohingya-camps>.

[5] As the responses of 3 unauthorized health practitioners were not included in the 'Flash Report', those interviews have been added to the latest round of interviews (numbering 2), making for 5 total.

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