The outbreak of COVID-19, response, and the vulnerabilities of Rohingya refugees in Bangladesh

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Bangladesh is a developing country in South Asia with a high density of population. The country is currently hosting more than one million Rohingya refugees from neighbouring Myanmar. The outbreak of COVID-19 pandemic has seriously affected the country. Obviously, it also has devastating impacts on the Rohingya refugees. By adopting a case study approach under qualitative research design, this study aims to explore and analyze the risks that make the Rohingya refugees vulnerable to COVID-19, the ways the pandemic increases their socioeconomic vulnerabilities, the preventive and protective steps and preparedness taken to protect the refugees, and the challenges the humanitarian workers face. Data was collected from official reports and documents, newspaper, journal articles and cell phone interviews with service providers and officials at Rohingya camps of Cox's Bazar district in Bangladesh. The densely packed living arrangement of refugee camps, gathering for different purposes and crowded environment increase the risks of COVID-19 infection. The government locked down the refugee camps declaring them as red zone areas and restricted entrance and departure. Many non-emergency services were decided to cease or squeeze. The UN agencies, humanitarian organisations and the government of Bangladesh (GoB) took multiple planned and coordinated actions focusing on COVID-19 related health services and preventive actions at the refugee camps. Evidence shows that service providers face several challenges while delivering services with limited resources under restrictions and changing contexts at the refugee camps. Thus, the outbreak of COVID-19 has jeopardized the wellbeing of women and children, people with a medical condition and elderly, and it deteriorated the prevailing socioeconomic crisis. Finally, the study suggests that the existing actions must be elaborated and strengthened with an active engagement of the Rohingya community.

Key words: *COVID-19, Rohingya refugees, Risks, Vulnerabilities, Response*

1.0 Introduction

The outbreak of novel coronavirus disease (COVID-19) has created an unexpected situation, fear and uncertainty across the world including Bangladesh. As of 3 August 2020, a total of 17,918,582 cases (and 686,703 deaths) of COVID-19 positive patients were reported across the world (WHO, 2020). Likewise, the number of cases in the South Asian countries including Bangladesh and India is also increasing gradually, where monsoon rains, flooding and other problems affect testing and control efforts (WHO, 2020). Since the virus has spread rapidly across almost all countries and affected all segments of society, it is recognised as a major threat to public health (Banik, Rahman, Sikder, & Gozal, 2020), and the World Health Organization (WHO) declared it a pandemic in early March 2020 (Islam, Bodrud-Doza, Khan, Haque, & Mamun, 2020). Due to the outbreak of COVID-19, the global health care system including Bangladesh is going on under severe pressure (Vonen, Olsen, Eriksen, Jervelund, & Eikemo, 2020). The elderly and people with medical conditions and poor living status are being more vulnerable to the risk of COVID-19 (Vonen et al., 2020).

UNHCR the UN refugee agency estimates that 79.5 million people were forcibly displaced across the world at the end of 2019, of which 26 million are refugees[1] and 80 per cent of them live in low-and middle-income countries (Lopez-Pena, Davis, Mobarak, & Raihan, 2020). The refugees usually live in insanitary and unhygienic conditions under densely and overcrowded living arrangements (Nott, 2020; The Lancet, 2020) with limited access to health care and information, safe water and sanitation, and other basic needs and resources (Kluge, Jakab, Bartovic, D'Anna, & Severoni, 2020). They are at increased risk of being infected with COVID-19 because of poor hygiene and living conditions, lack of medications and medical resources, complexities of executing disease prevention programmes (Kluge et al., 2020; Lopez-Pena et al., 2020; Sharma, Scott, Kelly, & VanRooyen, 2020; The Lancet, 2020; Vonen et al., 2020), and the difficulties in maintaining social distancing, isolation and quarantine at the refugee camps (Kluge et al., 2020; Vonen et al., 2020). Globally, state actions of border control, lockdown and travel restrictions to curb the spread of COVID-19 have affected the refugees as these actions pose serious challenges to continue humanitarian assistance and lifesaving services (Kluge et al., 2020; Sharma et al., 2020).

Bangladesh is a developing country in South Asia, which suffers from high population density (1103 per km²), poverty (21.8%), and frequent natural disasters, such as flood, river erosion and cyclone (Bangladesh Bureau of Statistics, 2020). The country detected the first case of coronavirus on March 8, 2020 (Banik et al., 2020) and since then it has tested 1,193,544 persons and confirmed 242,102 cases (and deaths 3,184 and recovered 137,905) (as of 29 July 2020) (WHO Bangladesh, 2020a). The government declared general leave (lockdown) from 26 March to 30 May 2020 to curve the spread of COVID-19 but failed to stop massive community

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[1] https://www.unhcr.org/figures-at-a-glance.html (accessed August 7, 2020)

transmission (Shammi, Bodrud-Doza, Islam, & Rahman, 2020) due to its high density, poor socioeconomic status, poor health infrastructure and health care facilities, poor governance, people's attitude to defy health hygiene and social distancing, lack of awareness and absence of adequate social safety net (Banik et al., 2020; Islam & Yunus, 2020; Islam et al., 2020; Khan, Islam, & Rahman, 2020). However, the country has mobilized stimulus package for the affected people and industries (Shammi et al., 2020) and developed health facilities gradually to fight COVID-19.

Bangladesh is hosting more than one million Rohingya refugees fleeing from Myanmar, of which around 860,000 are currently living in fragile bamboo shelters of the 34 extremely crowded refugee camp clusters of similar pattern in the south-eastern district of Cox's Bazar (ACAPS, 2020d; Islam & Yunus, 2020; Relief International, 2020, July 16; Vince, 2020; WHO, 2020, June 30). Although the camps vary by size, the physical structure, condition of the refugees and the problems they suffer are almost similar (Brockmann, 2020, April 30; Inter Sector Coordination Group Bangladesh, 2020a). The high population density (40,000 people per km²), lack of knowledge and awareness about COVID-19, limited access to water, sanitation and medical facilities, superstitions and rumours, and poor health and economic status may increase the spread of COVID-19 at the Rohingya camps (Islam & Yunus, 2020; Jubayer, Kayshar, & Islam Limon, 2020; Khan et al., 2020; Reid, 2020, June 12). The UN and humanitarian agencies are working with the government of Bangladesh (GoB) to prevent and control COVID-19 in the camps and host communities through joint and collaborative actions. However, the countrywide lockdown, restrictions of movement in the Rohingya camps and the situation created through COVID-19 affected the Rohingyas adversely, increased their vulnerabilities and made it difficult for the humanitarian workers to protect the Rohingyas as well as continue the humanitarian services (Inter Sector Coordination Group Bangladesh, 2020a; Sharma et al., 2020). Against this backdrop, this study aims to explore and explain the Rohingya's vulnerability to the risks of COVID-19, the actions taken, the challenges faced by the humanitarian agencies and the impacts on the Rohingyas.

2.0 The Rohingya refugees and their vulnerabilities to COVID-19

The Rohingyas are a Muslim ethnic group from the Rakhine state (former Arakan) of Western Myanmar (Burma) (Lewis, 2019). They are the survivors of state-sponsored violence and massacre in Myanmar. The Myanmar authorities regard Rohingyas different from the mainstream Burmese culture because of their distinct language, ethnicity, religion and history (Farzana, 2015; Mohsin, 2020). They have been deprived of citizenship rights as Myanmar treats them as illegal migrant from neighbouring Bangladesh (Lewis, 2019). The historical origin of the Rohingya crisis is complex. The Rohingya Arakanese have diverse historical origins. Their ancestors were from Arab, Persian and other traders who settled in the lower Burma in the ninth century or earlier (Farzana, 2015; Sahana, Jahangir & Anisujjaman, 2019). The Rohingyas had lived for a thousand years in Arakan, which was an independent kingdom

for around 2000 years (Mohsin, 2020). There was a historical rivalry between the Arakanese and Burmese king. The Arakanese began to rebel when the Burmese King Bodawpaya conquered and incorporated the Arakan region into his kingdom in 1784. Being oppressed by the King, they supported the British colonial power (Farzana, 2015) who seized some parts of Myanmar and incorporated them into British India in 1824. Since then, there were frequent movements of people between Bengal and Arakan (now Rakhine) where majority of the Rohingyas live. When Burma obtained independence in 1948, the Rohingyas were excluded from citizenship excusing that they were not part of the country's pre-1824 population (Lewis, 2019; Mohsin, 2020). Their situation worsened further in 1962 when the military occupied power and tried to create a Buddhist majority state. The Rohingyas finally became stateless through the Burmese citizenship law of 1982 (Mohsin, 2020; Sahana et al., 2019).

Since 1962 the Rohingyas have been excluded from state facilities and civil rights through discrimination, oppression, persecution, land appropriation, restriction of movement and denied citizenship rights (Sahana et al., 2019). Most of the Rohingyas began to cross into neighbouring Bangladesh and other Asian countries since the 1970s, being denied from citizenship rights, oppressed, discriminated and persecuted (Crabtree, 2010; Inter Sector Coordination Group Bangladesh, 2020a; Tay et al., 2018; Vince, 2020; White, 2017). More specifically, the military crackdown and continuous conflicts and instability pushed a large number of Rohingyas to move to Bangladesh in 1978, the early 1990s, 2007, 2012 and 2016 (Khan et al., 2020; Lewis, 2019; Sahana et al., 2019; White, 2017). Around 200,000 Rohingya Muslims escaped to Bangladesh due to the military operation in 1977 called Na-Ga-Min (Dragon King) to curtail illegal intruding into Myanmar. Later, around 270,000 Rohingyas took refuge in Cox's Bazar being expelled by the military operation in Arakan state in 1991. Subsequently, many Rohingya Muslims fled to Bangladesh due to the communal violence between Rakhine Buddhist and Rohingya Muslims during 2012 to 2014. Finally, the military crackdown in 2016 forced around 600,000 Rohingyas to seek shelter in Bangladesh (Lewis, 2019; Reid, 2020, June 12; Sahana et al., 2019).

Over the years, the Government of Bangladesh has been assisting by giving shelter to the Rohingyas in different Refugee camps of Cox's Bazar with the help of UN and other national and international humanitarian agencies (Inter Sector Coordination Group Bangladesh, 2020a; Khan et al., 2020; Lewis, 2019). The Rohingyas live in the densely packed cluster of camps in different locations of Cox's Bazar (as shown in picture 1) and suffer from the scarcity of water and sanitation, malnutrition, inability to fulfil basic needs and limited access to essential services (ACAPS, 2020b; Khan et al., 2020; Vince, 2020; White, 2017). About 860,356 people and 187,423 families live in the 34 Rohingya camps, of which 51% are children, 45% adults, 4% older, and 1% persons with disabilities; and almost all of them are vulnerable to some kind of risks (Government of Bangladesh & UN High Commissioner for Refugees, 2020, June 30). They are also vulnerable to seasonal cyclone and monsoon rains causing floods and landslides (Inter Sector Coordination Group Bangladesh, 2020a; Reid, 2020, June 12), crime, violence

and trafficking, poverty, indebtedness, food insecurity and poor sanitation (ACAPS, 2019; Ahmed, 2020, June 30).

Picture 1: A view of a refugee camp in Cox's Bazar, Bangladesh showing densely poor housing patterns and living arrangements (Photograph taken by the researchers).

As described elsewhere, the Rohingyas are highly vulnerable to the risk of COVID-19 infection because of the overcrowded and unhealthy living arrangements, poor housing, limited access to water and sanitation, nutritional deficiencies, poor health status, mortality and morbidity risks, underlying medical conditions of some people, difficulties in following health safety rules, and insufficient health, medical and other resources and facilities (ACAPS, 2020b; Ahmed, 2020, June 30; Inter Sector Coordination Group Bangladesh, 2020a; Jubayer et al., 2020; Khan et al., 2020). The government locked down the refugee camps since March 2020 to protect the Rohingyas (Jubayer et al., 2020). The GoB, UN agencies and several national and international humanitarian agencies have taken preparedness and planned, coordinated and joint actions related to awareness-raising, prevention and protection, testing and treatment, isolation and quarantine to protect the refugees and host communities in Cox's Bazar from COVID-19 with an engagement of community leaders and volunteers (Inter Sector Coordination Group Bangladesh, 2020a; Khan et al., 2020; WHO, 2020, June 30). As of July 29, 2020, a total of 3,231 cases from host communities (and deaths 53) of Cox's Bazar and 66 from Rohingya refugees (and deaths 6) were confirmed COVID-19 cases, and only 1,724 Rohingyas conducted coronavirus test (WHO Bangladesh, 2020b, p. 1). The number of test and death is low because many Rohingyas with coronavirus symptoms do not come forward to get tested due to stigma, rumours, superstitions, anxiety, fear, lack of trust on health care providing agencies and lack of awareness (ACAPS, 2020a; Islam & Yunus, 2020). Therefore, stakeholders (GoB, UN and humanitarian agencies) have introduced massive awareness programmes and extensive health programmes to address the socioeconomic risk factors of

COVID-19 and continue many emergency and essential services as preventive and protective actions (Inter Sector Coordination Group Bangladesh, 2020a). The restrictions on movement into the camps, reduction and squeeze of non-essential services, leaving of aid workers from the camps, mistrust of Rohingyas about the healthcare system and rumours and superstitions are the big challenges for the service providers working at the refugee camps (Ahmed, 2020, June 30; Khan et al., 2020). Thus, the outbreak of COVID-19 in Rohingya camps and host communities and the administrative actions taken to control the virus have affected the Rohingyas in multiple ways, especially in health, education, income and movement (Ahmed, 2020, June 30).

3.0 Research questions

The research intends to seek answers to the following research questions. These are:
1) Why are the refugees of Rohingya camps in Bangladesh vulnerable to COVID-19 and in what ways the pandemic increases their vulnerabilities?
2) What are the preventive and protective steps and preparedness actions taken to address COVID-19?
3) What challenges do the humanitarian workers and other service providers face in fighting COVID-19 in Rohingya camps?

4.0 Objectives of the research

Generally, the study aims to explore the Rohingya refugees' vulnerabilities to COVID-19 pandemic and the actions taken for their protection. The specific objectives are:
1. To explore the infrastructural, social, cultural and behavioural risk factors that make the refugees vulnerable to the risk of COVID-19.
2. To gain insight into the actions taken by multi-stakeholders to protect the refugees.
3. To identify the barriers that make it difficult to fight against COVID-19 at Rohingya refugee camps.
4. To explain the impacts of COVID-19 on the Rohingya refugees.

5.0 Methodology

The study adopted a case study approach under qualitative research design to understand deeply and extensively (Creswell, 2013) the risks, actions taken and vulnerabilities of the Rohingya refugees related to COVID-19 pandemic by collecting data from both primary and secondary sources. The case in a case study research may be individuals, groups, organisations, events, etc. (Neuman, 2014). In this study, all the Rohingya refugees living in 34 camps of Cox's Bazar in Bangladesh were considered a case since the refugees as a distinct ethnic group live in a similar pattern of camps with similar problems, vulnerabilities, daily sufferings and lifestyle. The study did not highlight the individual variation among the camps. Instead, it

focused on the common risks and problems that the refugees face due to the spread of COVID-19 and the actions taken in this regard. By approaching some service providers at Rohingya camps working under a different government, UN and humanitarian organisations through personal contact, we conducted cellphone interviews with 8 respondents, who agreed to participate voluntarily and spontaneously (Neuman, 2014). Table 1 shows that the participant respondents work under different UN agencies, national and international NGOs (Non-governmental organisations) and the GoB. It also shows other characteristics, such as gender, age, the nature of job and the duration of working experience with the Rohingya communities.

Table 1: Information about the respondents

Respondents	Gender	Age	Type of organization	Nature of work	Working in Rohingya camps
Respondent 1	Male	39	UN agency	Field level monitoring	Since 2017
Respondent 2	Male	42	International NGO	WASH (Water, sanitation and hygiene) sector manager	Since 2015
Respondent 3	Male	44	UN agency	Water and sanitation management (Non-medical)	Since 2009
Respondent 4	Male	42	UN agency	Senior management	Since 2016
Respondent 5	Female	32	National NGO	Field level employee	Since 2016
Respondent 6	Female	35	International NGO	Management (Mid-level)	Since 2012
Respondent 7	Male	29	National NGO	Protection monitoring	Since 2017
Respondent 8	Male	31	GoB	Field level administration	Since 2018

In a case study research, data are usually collected from documents, reports, archival records, observations, audiovisual materials and interviews (Creswell, 2013). We collected primary data through cellphone interviews with service providers and officials using a semi-structured interview guideline. The researcher themselves conducted the interviews considering the convenience of the participants. We recorded the conversations taking prior permission, and then transcribed the narratives. The secondary data were collected from documents and reports, newspaper, journal articles, blogs and online media that exclusively focused on Rohingya refugees and COVID-19. The study period was from May 2020 to July 2020.

After interviews, we prepared a transcript of every interview and read the script line by line. Thus, we identified, selected and explained the key issues or themes. The data collected from secondary sources were also classified under different themes, explained and analyzed by blending them with the primary data. The study followed the basic ethical principles of social research with vulnerable groups (Neuman, 2014). We did not use any personal information that may cause any kind of harm to the refugees or our research participants. We briefed the research participants about the study objectives and outcome before interview and ensured their oral informed consent. We did not use a name to ensure anonymity and presented data in a way that ensured privacy and confidentiality (Neuman, 2014).

5.0 Findings and analysis

5.1 The risks of COVID-19

There is a rapid transmission of COVID-19 in Bangladesh because of the absence of enough COVID-19 testing and medical facilities and public awareness (Banik et al., 2020). Therefore, there is also a risk of community transmission from host communities to Rohingya camps through the movement of humanitarian workers and others.

> The host population are responsible for spreading COVID-19. The Rohingyas only go outside in case of an emergency after getting permission from the CIC (Camp in Charge). Some Rohingyas were infected because of the movement of NGO workers and others from outside. (Respondent 1)

The physical infrastructure of refugee camps is dangerous for COVID-19 infection because maintaining social distance and following hygiene rules in such environment are difficult (Vince, 2020). The poor housing, the congested and crowded living arrangements (40,000 to 70,000 people live per km²), community sharing of water, toilet and washing facilities, gathering for different purposes and barriers of getting access to reliable information due to weak internet connectivity may spread COVID-19 ("Efforts to tackle COVID-19 stepped up in Rohingya and host communities in Cox's Bazar," 2020, April 26; Nott, 2020; Relief International, 2020, July 16; Smith & Uddin, 2020; UNHCR, 2020, May 15).

> It is impossible to maintain 'social distance' and 'physical isolation' inside the houses as 7 to 8 people on an average live per room. If anyone is infected, nothing will work and raising awareness will go in vain. (Respondent 1)

> It is a big challenge to maintain social distance at densely populated Rohingya camps. However, the programs of distributing cloth masks to the families are going on with the help of health sectors. (Respondent 8)

The real-life situations at refugee camps, lack of awareness, insufficient knowledge about symptoms and hygiene practices, apathy to receive information, distrust or negative perception about health care, faith in superstitions and traditional treatment, fear of reporting symptoms, panic, phobia, shame and stigma, fatalism and gathering for prayer and other purposes may increase the risk of community transmission (ACAPS, 2020d, 2020g; Brockmann, 2020, April 30; Jubayer et al., 2020; Lopez-Pena et al., 2020).

> Coronavirus may spread in the camps because of illiteracy, lack of necessary hygiene facilities, inability to realize the danger of COVID-19, having less faith in the modern

health system, disregarding the health safety rules and the beliefs that Muslims are not infected with COVID-19. (Respondent 6)

The number of contaminated persons may be more as the Rohingyas are unwilling to test. They hide information as they have anxiety or phobia about going to isolation centres or unknown places. It is impossible for them to maintain social distance while they gather to receive food baskets. (Respondent 2)

Superstitions and religious beliefs may increase Rohingyas' vulnerability to COVID-19 infection. They believe that COVID-19 is a punishment sent by Allah and they continue gathering for religious practices (ACAPS, 2020c, 2020f).

They (Rohingyas) do not try to understand the disease, rather believe in fatalism saying that "Allah gives diseases and Allah will cure us". (Respondent 1)

The information related to COVID-19 was disseminated through community leaders (*Majhis*), mosques, religious leaders and other functional channels. But they do not care for it. They say, "it is a curse of Allah on people and we shall not be affected" and "it is a disease for the rich, but not for the poor". (Respondent 2)

Initially, there were rumours and misconceptions among the refugees that if people were infected, then they would be taken away and killed or people might attack them. This discouraged them from reporting symptoms and approaching health facilities (ACAPS, 2020b, 2020d; Brockmann, 2020, April 30; Rahman & Yeasmine, 2020, July 24).

Initially, they have spread rumours like "if anyone is corona (COVID-19) infected, he/she will be isolated and killed, and his/her family will never know about his/her whereabouts". (Respondent 1)

Many believe that if tested positive, the government will send them to Vashan Char (an island in the Bay of Bengal). It discourages them in testing COVID-19, despite having corona symptoms. (Respondent 3)

GoB and other partner organisations took drastic measures to control and stop rumours and develop trust and awareness among the people through active engagement of community volunteers and leaders (Brockmann, 2020, April 30; Inter Sector Coordination Group Bangladesh, 2020b).

The government officials investigated the source and spreader of rumours and punished them accordingly. Government also warned people through mosques and other ways. (Respondent 1)

> I have been working here since 2009. I know that rumours can spread like branches of trees as the refugees are living in uncertain situations in congested areas. All the agencies are seriously working to stop rumours in all possible ways. (Respondent 3)

Due to awareness programmes, door to door visit, discussions at different points, expansion of COVID-19 related services and information flow, people's perception about rumours, hygiene and risks have changed gradually (Mohsin & Reidy, 2020, April 23; UNHCR, 2020a).

> Over the last one month, there is a change among the Refugees. They observe that we are not going to the camps regularly. They are not getting regular services like earlier normal situations. The Bengali people are also not going to the camps due to COVID-19. (Respondent 1)

5.2 Actions taken

Several agencies of importance, such as IOM (International Organization for Migration), UNHCR, WHO, WASH Program and other national and international non-governmental agencies are involved in Bangladesh, each having its own mandate. They work at the grassroots and also with the government to achieve the sustainable development goals (SDGs) and assist in reducing poverty, and improving socio-economic development and health (Hossain, 2014; Stiles, 2002). While the first two are primarily engaged with the concerns of refugees, with the spread of COVID-19, all agencies are involved at the grassroots in the pandemic work and coordinating with each other in relation to each other's primary mandate.

The government of Bangladesh (GoB) locked down the refugee camps and restricted entry. The roads leading to the refugee camps were blocked for all except the emergency service providers (Smith & Uddin, 2020) and Cox's Bazar area was declared red zone (Islam & Yunus, 2020) as preventive measures.

On 24 March the Refugee Relief and Repatriation Commissioner (RRRC) instructed to operate the essential services to decrease the number of aid workers in the refugee camps and reduce the risk of COVID-19. The RRRC further narrowed down the scope of operation of services to only critical services related to health, nutrition, food, fuel distribution, hygiene promotion, hygiene kit distribution, water and sanitation, construction of health facilities, site management, etc. with a consultation and coordination with the UN and other humanitarian agencies since 8 April. The DC (Deputy Commissioner) of Cox's Bazar district lead the overall response and actions at the district level and the RRRC coordinated the responses and activities in the refugee camps. The district civil surgeon oversees the medical response, technical and treatment activities related to COVID-19. The Bangladesh

army supports the civil administration (Inter Sector Coordination Group Bangladesh, 2020a, pp. 12-13; UNHCR, 2020a).

> The government has restricted all movements and taken initiatives to maintain lockdown. It was like a state of emergency. NGOs staff were cut to avoid the possible transmission of COVID-19. (Respondent 3)

> The authorities have restricted the movement of foreigners and any gathering or meeting inside the camps to control coronavirus. All non-essential activities, such as education, women and child-friendly centers have been stopped except some emergency services including food, shelter, treatment and WASH. (Respondent 8)
> The law enforcement agencies check at the entrances and human gathering inside the camps. NGOs were advised to halt programmes with mass gatherings. Lots of humanitarian agencies are distributing hygiene kits, such as mask, soap, towel and sanitizer and training people about handwashing and other hygiene practices. Awareness programmes are going on from door to door through sending a message and using the mosque microphone. (Respondent 6)

The UN and other local, national and international humanitarian agencies and development partners rapidly took multifarious efforts and preparedness to fight COVID-19 in the camps as well as host communities of Cox's Bazar jointly with the GoB ("Efforts to tackle COVID-19 stepped up in Rohingya and host communities in Cox's Bazar," 2020, April 26). All stakeholders took rapid actions, strengthened and intensified the responses and implemented programmes through proper coordination, collaboration, planning, monitoring and evaluation (Centre for Research and Information, 2020 July 5; UNHCR, 2020, May 15; WHO Bangladesh, 2020b). Decisions were taken and changed through monitoring and evaluating the real situations and conducting regular meeting among and between the stakeholders and community volunteers (UNHCR, 2020a; WHO Bangladesh, 2020b). The stakeholders took necessary preparations in early March considering the outbreak of COVID-19 in Bangladesh (Vince, 2020).

> We discontinued earlier awareness programmes and instead began to emphasize only the health and hygiene promotion and awareness programmes related to COVID-19. WASH and government health sector coordinated the awareness programme and made some key guideline messages to raise awareness among the refugees. (Respondent 2)

> To control the coronavirus, health sectors of GoB, other ministries and stakeholders are working jointly. There are restrictions of movement and gathering in the camps. There are quarantine, isolation, and treatment facilities in the camps, where health workers work for 24 hours. (Respondent 8)

Efforts were taken to strengthen awareness programmes, build community trust, offer training to the community volunteers to work in absence of humanitarian workers, develop capacity and facilities of local government hospitals for COVID-19 treatment, improve testing and treatment facilities, provide medical equipment like masks and PPE (personal protective equipment) to the frontline workers and build isolation spaces and quarantine centres for the refugees and host communities ("Efforts to tackle COVID-19 stepped up in Rohingya and host communities in Cox's Bazar," 2020, April 26; Inter Sector Coordination Group Bangladesh, 2020a; IOM Bangladesh, 2020; UNHCR, 2020, May 15; WHO Bangladesh, 2020b). The existing health centres and facilities were fully used to fight COVID-19 inside and outside the camps with necessary training and resources (UNHCR, 2020, May 15). Measures were taken to control the outbreak of COVID-19 through diversified actions, such as risk communication, disease surveillance, community engagement surveillance, actions of the rapid response team and case management, and infection prevention and control (Inter Sector Coordination Group Bangladesh, 2020a; IOM Bangladesh, 2020; Islam & Yunus, 2020; UNHCR, 2020, May 15; WHO, 2020, June 30; WHO Bangladesh, 2020b). With an active engagement of community-based volunteers and community leaders, the health sector agencies took all initiatives to inform the refugees about COVID-19, the importance of behavioural changes and treatment and other facilities through a door to door visit, radio programmes and mike services (Inter Sector Coordination Group Bangladesh, 2020a; Mohsin & Reidy, 2020, April 23; UNHCR, 2020b; WHO, 2020, June 30; WHO Bangladesh, 2020b).

> Leaflets were distributed in Bangla and Burmese language to make people aware. All field-based hospitals and health centres inside the camps were given necessary instructions. (Respondent 8)

> We emphasise more on prevention than cure. We are making isolation centres, distributing masks and protective equipment, operating activities in each facility centre following health safety rules, establishing thermal scanner at the entrance, building isolation and quarantine centres, treatment centres and ICU (intensive care unit), and doing everything following social distance. (Respondent 5)

> Emergency and mobile medical teams are working using emergency ambulance services. (Respondent 4)

Picture 2: Health teams instruct Rohingya refugees in Bangladesh on proper hygiene techniques © IOM 2020 (Reproduced with Permission)

Picture 3: IOM health staff prepares isolation centres in Rohingya camps © IOM 2020 (Reproduced with permission).

If anyone was tested positive and unwilling to go to isolation centres, then the law enforcement personnel and magistrates force the person to ensure isolation. RRRC staffs selected from the young refugees are very active in tracing the positive patients and ensuring isolation and quarantine. (Respondent 1)

Whenever symptoms are observed, designated people come and collect the samples for testing and identify the people with symptoms through volunteers and *Majhis*. The civil

surgeon monitors the activities; and UN organisations and NGOs work jointly. (Respondent 2)

The community outreach volunteers were trained up to share information with the refugees, visit houses to share and collect information, look for the people with COVID-19 symptoms, act as a bridge between the refugees and health facilities, build trust among the refugees, *Majhis* (community leaders) and Imams (religious leaders), help the elderly and critical patients in accessing services, facilitate field level activities on collecting COVID-19 samples, isolation and quarantine services, and counter rumours in the camps (Centre for Research and Information, 2020 July 5; Inter Sector Coordination Group Bangladesh, 2020b; Rahman & Yeasmine, 2020, July 24; UNHCR, 2020a, 2020, May 15; WHO Bangladesh, 2020b). They played a significant role in community-based surveillance and counselling activities with the refugees with symptoms and develop their understanding about COVID-19 testing, treatment and other necessary measures (Mohsin & Reidy, 2020, April 23; Rahman & Yeasmine, 2020, July 24; UNHCR, 2020b).

UNHCR trained psychologists, community psychosocial volunteers and community outreach volunteers to raise awareness and counsel people related to COVID-19 response (UNHCR, 2020a). WHO also provided necessary technical supports related to mental health and psychosocial support to minimize the impacts of COVID-19 (WHO, 2020, June 30). However, mental health services are not emphasized like other emergency health services.

Psychosocial support is given to the refugees in the camps (Respondent 7)

Services related to mental health are almost unavailable during this COVID-19 pandemic. (Respondent 4)

The agencies share messages with the refugees through radio spots, videos and posters, and use Rohingya, Burmese and Bangla language to make them understand (UNHCR, 2020, May 15; WHO Bangladesh, 2020b).

People are asked to maintain social distance using hand mike during any gathering. In each entry point or crowded places, volunteers work to ensure handwashing with soap and water. At the main entrance of camps, temperature screening system along with handwashing devices have been set up. (Respondent 2)

5.3 Challenges, outcome of services and actions required

It is quite difficult to ensure preventive measures, such as social distancing, home-based isolation and quarantine in the crowded camps. The low level of education and superstition pose additional challenges in raising awareness (Smith & Uddin, 2020; WHO, 2020, June

30). The service providers face significant challenges in maintaining physical distance while providing services related to shared water, sanitation and washing facilities, and distribution of food, mask and fuel (ACAPS, 2020b; Brockmann, 2020, April 30; Lopez-Pena et al., 2020; Smith & Uddin, 2020; UNHCR, 2020, May 15). Initially, it was not possible to distribute masks, but a huge number of masks are being distributed gradually (UNHCR, 2020b).

> Many Rohingyas believe that being Muslims they will not be infected with the coronavirus. Such stereotyped idea discourages them to be aware of it. (Respondent 7)

> It is challenging for the health workers to convince the refugees to follow the WHO guidelines. People are panicked when someone is infected and isolated, and three to four houses are locked down subsequently. They are not interested to tell anyone if there is any symptom because, they think, it may cause the arrival of police, isolation from the community and harassment and humiliations of families through lockdown… When someone is sent to isolation he cries like a child as most of them are ignorant. Some leave the isolation centre without telling.…. In many FGDs, they opined that "we would rather die than inform that we are infected with COVID-19" *(ara morijium, no khoium)*. (Respondent 1)

> It is almost difficult to maintain hygiene, lockdown, isolation and social distance in congested camps with lack of health and sanitation facilities (Respondent 4).
> It is difficult to work with the refugees due to their lack of awareness and social and religious prejudice. (Respondent 5)

> The Rohingyas blame the officials and service providers for bringing coronavirus in the camps. (Respondent 7)

> They (Rohingyas) do not take corona seriously, rather believe in rumour. They do not respond if asked. Huge gathering in small places, hidden movement of Rohingyas inside and outside the camps, tendency to disobey health rules, shortage of PPE and sufferings on the road due to traffic jam are the challenges we face while working in the camps. However, the situation is better than before. (Respondent 6)

Although the partner organisations are extending support to establish ICU in COVID-19 hospitals, building treatment, isolation and quarantine centres inside the camps (ACAPS, 2020b; Mohsin & Reidy, 2020, April 23), these will not be enough if there is a rapid spread of the virus. The number of health care professionals are not enough to serve the patients. It is a big challenge to increase the number COVID-19 tests since many of the Rohingyas with symptoms do not go to the health facilities due to fear of isolation or knowledge gap (ACAPS, 2020g; Rahman & Yeasmine, 2020, July 24; Relief International, 2020, July 16).

Necessary services cannot be executed since 80% of all humanitarian agencies are not allowed to work in the camps (ACAPS, 2020e). It is also difficult to serve the critical patients due to travel restrictions (Brockmann, 2020, April 30). Rohingyas are often indifferent to receiving treatment owing to distrust and lack of confidence in the medical services (ACAPS, 2020d).

> There are still risks for COVID-19 infection as the Rohingyas have less faith in the doctors and the treatment systems. Some are afraid that doctors can kill them, if found infected, and therefore, they are afraid of going to the hospitals. (Respondent 6)

Despite the challenges, the low number of COVID-19 infections (Relief International, 2020, July 16) indicate that joint multi-stakeholder actions have a positive impact (Centre for Research and Information, 2020 July 5), though there are significant risks of the massive spread of the virus. The stakeholders (Centre for Research and Information, 2020 July 5) and the research participants are pleased with the joint actions taken by the GoB and other agencies and their outcome.

> The actions taken by the government of a developing country like Bangladesh and other NGOs for Rohingyas are really appreciating. The rich countries are struggling to address COVID-19. In that sense, enough is done…. The number of deaths with symptoms is roughly around fifty out of one million refugees. It is indeed a small number. It is a big success story for all organisations working under the coordination of RRRC. But everything is not going on as planned. (Respondent 6)

> The joint actions were successful in controlling coronavirus at the Rohingya camps. It could be realized from the statistics of low number of infection and deaths in the refugee camps. (Respondent 8)

UNHCR and other agencies are taking preparation to introduce home-based care for the COVID-19 patients along with the existing services in the camps, if the number of positive patients increase (UNHCR, 2020b). Research participants also suggested that further actions are needed to control COVID-19 at refugee camps.

> Many things are unheard and unreported since none from police, government administration or service providers work at camps from 4 PM to 9/10 AM. We could not develop a mechanism to serve during these hours. (Respondent 1)

> I think there is a need for ventilation in the housing and more ICU in the hospitals. (Respondent 7)

I think test facilities should be increased. The movements of the Rohingyas from camp to camp should be restricted, and strict measures must be taken to enforce the quarantine. (Respondent 5)

The role of law enforcement agencies should be ensured and strengthened to control gathering inside the camps and engage them in distributing necessary items. (Respondent 6)

Initially, the infected refugees were forced to go to the isolation centres due to some problems, which were resolved with the help of UNHCR. Still, there is a lack of enough doctors and nurses with adequate infrastructure. (Respondent 2)

5.4 Impacts

The restrictions on movement and suspension of non-essential activities related to shelter, livelihood, protection, education and learning, training, friendly spaces, community centres, and shops and markets (ACAPS, 2020e; "Efforts to tackle COVID-19 stepped up in Rohingya and host communities in Cox's Bazar," 2020, April 26) affected the life and livelihood of Rohingya refugees. The humanitarian organisations could not work due to countrywide lockdown (Jubayer et al., 2020) and faced difficulties in continuing critical services under restriction at refugee camps (Islam & Yunus, 2020).

Many regular essential works are halted now. For example, we cannot clean 150 toilets in a block and work for the smooth operation of a network of supply of water. (Respondent 2)

The essential service of registration is being discontinued, which creates complexities in distributing rations to the family members. Due to the global and countrywide disruption in the supply chain, there was a shortage of some necessary food items and the Rohingyas could not be provided with all the necessary food items that they could get before the pandemic. We also stopped infrastructural development works and repairing or making of house with bamboos due to lockdown. (Respondent 1)

Although the refugees are not legally allowed to work outside the camps, they were engaged in some wage-earning activities (Crabtree, 2010). Due to lockdown and restrictions, they could not work and earn anything. Consequently, their dependency on relief assistance and debt increased, which made them vulnerable to malnutrition and the risk of exploitations (ACAPS, 2020a).

> Some Rohingyas were working as labourers in each camp. Now they cannot work, and they solely depend on food and ration supplied by WFP (World Food Programme). (Respondent 2)

Women and girls could be affected disproportionately due to existing gender norms and roles; and the survivors of gender-based violence would not get needed services (ACAPS, 2020e; Inter Sector Coordination Group Bangladesh, 2020a). The difficulties of family earning may lead the adolescent girls and young women in the risk of sexual exploitation (Inter Sector Coordination Group Bangladesh, 2020a). Immunization programmes were halted temporarily and the participation rate declined drastically (ACAPS, 2020a; WHO Bangladesh, 2020b), which may increase child mortality. The maternal and child death rate may increase due to the disruption in healthcare systems and reduced participation in antenatal and reproductive healthcare programmes and hospital services (ACAPS, 2020a; Mohsin & Reidy, 2020, April 23). The reduction of non-emergency services (ACAPS, 2020a; WHO, 2020, June 30) may decrease social cohesion, increase criminal activities and trafficking (ACAPS, 2020a) and hamper child protection programme for the separated children (UNHCR, 2020a).

The children and adolescent can no longer have access to education or training (ACAPS, 2020a), which may cause emotional disturbance and anxiety and motivate them to adopt unhealthy coping mechanism (Inter Sector Coordination Group Bangladesh, 2020a).

> Schools and child-friendly spaces are closed, where they could sing, learn, play and practice arts. Now they roam like the adults. (Respondent 2)

> The normal lifestyle of the children is being hampered. (Respondent 7)

> Children are now living with high risks in the camp area due to lack of education, recreation, malnutrition and boredom. (Respondent 4)

The elderly population and people with disabilities and medical conditions are at higher risk of COVID-19 (Inter Sector Coordination Group Bangladesh, 2020a; UNHCR, 2020b). Now it is quite difficult to provide medical and psychosocial services through home-based outreach services. Failing to access necessary services may aggravate health problems along with loneliness, depression and other psychological problems (ACAPS, 2020a). The outbreak of COVID-19 may further complicate the barriers that people with disabilities face in getting access to essential services and aid (ACAPS, 2019).

> The elderly people are restricted to visit the old friendly spaces. There were doctors and other facilities available for old people, which are stopped also. A new guideline for working with elderly and disabled people have been developed, and some NGOs are

working accordingly. They are providing messages about the vulnerability of older people to COVID-19 and motivating them to avoid mass gatherings. (Respondent 2)

The elderly people are always vulnerable in Rohingya camp. The number of elderly people receiving treatment decreased, but the death rate increased. (Respondent 4)

There are no significant services available for the disabled people. (Respondent 7)

6.0 Limitations of the study

The researchers could not visit the refugee camps and conduct face-to-face interviews with some potential group of respondents because of the risks and restrictions of movements into the camps. Considering the current situation, we approached and selected a small number of research participants purposively from some organisations working at the refugee camps. The study might have explored more reliable and in-depth information about force, suppression or violation of human rights (if there was any), the experience and opinions of the refugees, their actual needs and problems and the limitations and gaps in the services, if we could conduct interviews with the Rohingya volunteers and population. Moreover, the use of more documents produced through independent research could be more insightful, authentic, and helpful to explain the realities.

7.0 Discussion and Conclusions

This study investigated and explained some risk factors of COVID-19, the actions undertaken by multiple stakeholders and the challenges they face, and how COVID-19 situation increased socioeconomic vulnerabilities of the Rohingya refugees in Bangladesh. The physical infrastructure of the camps, communal sharing of water, sanitation and washing facilities, rumours, superstitions, unwillingness to get tested for COVID-19, etc. were identified as potential risks for the spread of COVID-19. The GoB, UN and several humanitarian agencies took preventive and protective measures related to testing, treatment, development of infrastructure and facilities, mask distribution, case management, counselling, awareness-raising through community engagement and training of volunteers and professionals to protect the refugees. However, it is challenging to implement preventive actions due to huge gatherings, illiteracy, superstitions and restrictions of movement. The coordinated efforts of multi-stakeholders were found effective in addressing the situations created through COVID-19, though further actions are required to motivate the refugees with symptoms to participate in COVID-19 testing and avail the opportunities in health centres. Since many non-emergency services were cut or squeezed and resources were used to protect the refugees from virus infection, these increased the vulnerabilities of the women, children, elderly and persons with disabilities.

Despite the risk of spread, the number of COVID-19 infected people and deaths is still very low in the refugee camps. The planned, quick and drastic actions taken by the stakeholders with proper monitoring and site management and coordination were found useful to curb the spread of COVID-19. However, the study suggests that extensive independent studies with the participation of the Rohingya refugees are needed to gain insight into the social, psychological, economic and health impacts. To control the spread of the virus, efforts should be taken to increase the number of COVID-19 tests and relevant facilities, strengthen and elaborate activities related to surveillance, treatment, preventive actions, isolation and quarantine facilities with active community engagement and securing the safety of health care and other professionals (Nott, 2020). Although all the organisations working in the camps are working effectively and efficiently (Centre for Research and Information, 2020 July 5), more funding and global support with active community engagement are crucial to raise awareness and build trust among the refugees, restart and extend critical services for the more vulnerable groups, and execute the planned actions to limit further spread of the virus and address the vulnerabilities of the refugees (ACAPS, 2020a; Inter Sector Coordination Group Bangladesh, 2020a; Islam & Yunus, 2020; The Lancet, 2020; UNHCR, 2020, May 15). Though it is difficult to follow exactly the WHO guidelines related to COVID-19, non-emergency services should be restarted quickly through proper planning and management (ACAPS, 2020a; Jubayer et al., 2020).

Acknowledgments

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