



Overview of Rohingya Perceptions

Edition #1, 26th March 2020

Executive summary

This report is based on 25 focus group discussions (FGD) and Key Informant Interviews (KIIs) with Rohingya living across Ukha and Teknaf Camps. Discussions took place between the 15th and 19th of March, 2020 and were conducted primarily by Rohingya Communication with Communities (CwC) Volunteers who recorded and transcribed discussions. The objective of these consultations is to ensure Rohingya's voices are included in all stages of the COVID-19 response and provide an avenue for Rohingya refugees to express their questions and concerns. COVID-19 Explained aims to provide decision makers with an understanding of the current perceptions, understanding and information being circulated about COVID-19 among Rohingya within the camps and inform programming decisions that are being made in preparation for a potential COVID-19 outbreak. These consultations will also feed into messaging and outreach strategies designed and implemented by IOM and other humanitarian response agencies.

Key findings and recommendations

For COVID-19 information needs:

- **People need to understand that the virus is not fatal and be given an honest series of messages regarding actual risks and treatment plans.** The approved messaging must be accompanied with complimentary messaging to address the rumours and misperceptions surrounding the fatality, spread, and treatment of the virus. People believe the virus is always fatal, don't know who is at risk, and don't understand the difference between prevention, transmission and treatment.
- **The virus needs to be presented as an illness which can be treated and prevented through normal measures.** People suspected of infection are being highly stigmatized. This is leading to under-reporting of symptoms and causing harm to people who are suspected of having COVID-19. Messaging that addresses stigmatization and encourages reporting of symptoms is of critical importance.
- **More nuanced and detailed understanding of Rohingya religious traditions and how these relate to COVID-19 guidance are critical. The current programming is not effective at transforming attitudes and simply aims to "replace" existing norms and traditions.** It is important to realize that that Rohingya religious traditions have been a key coping strategy historically that have allowed them to deal with disasters, political persecution and other hardships. Rohingya will rely on these beliefs and practices through the COVID-19 crisis and humanitarians need to develop more nuanced approaches to engage with religious beliefs that transform interpretations instead of forcibly change existing value systems.





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Community engagement:

- **Prevention, isolation and treatment of COVID-19 cases will never be effective unless the humanitarian community begins to listen and actively engage with Rohingya on their opinions on these issues.** Rohingya concerns over issues like being isolated away from family members are real, valid, and shared by many people internationally. Engaging in these perspectives and including their recommendations will drastically improve Rohingya's willingness to adopt healthcare guidance, report symptoms, isolate, and seek treatment. These consultation series will aim to make these demands clearer in subsequent editions.
- **Religious leaders to be engaged more effectively with a nuanced strategy that reflects their particular beliefs and their supporting logic.** Many Rohingya's perspectives reveal the centrality of their religion in their understanding of the virus and engagement with Rohingya populations needs to be focused on transformative approaches instead of "enforcing new interpretations."
- **Self-organized Rohingya groups are actively engaged in awareness raising activities and need to be included, oriented and engaged in the response.** They can be powerful allies in convincing the wider population to adopt appropriate health measures and have high levels of trust with the community. It is incredibly important that all Rohingya actors seeking to be part of the response are included. They can be engaged to observe and monitor the service provision and relay this information to the wider community to build trust.

Addressing healthcare perceptions:

- **Humanitarian responders need to adopt transparency surrounding all of their actions and communicate clearly and pro-actively to Rohingya in order to build trust and address rumours.** Mistrust regarding healthcare provisions stems from miscommunication, poor treatment, and previous negative experiences with healthcare providers in the camps and possibly Rakhine. Transparency and clear communication are critical in improving these relationships and perceptions.
- **Community feedback mechanisms on health services need to be improved and healthcare provision must be better explained in understandable language.** People have many complaints related to healthcare and humanitarian services that remain unaddressed. Others do not understand the guidance provided to them at clinics. Speaking openly will improve trust, services, and expectations of medical treatment. This will be explored further in this series.
- **Healthcare measures and messages needs to be designed in ways that align with religious practices and needs if they are to be adopted by the population.** Religious considerations surrounding prayer, burials, and isolation all need to be considered with respect to Rohingya's culture and history. Many Rohingya believe the cause of the disease to be religiously based. This is unlikely to change rapidly over the course of the epidemic and instead "areas of overlap" between religious beliefs and healthcare guidance must be identified.



Introduction

IOM and ACAPS have started, since the 18th of March, to track community perceptions surrounding COVID-19 and the response within Cox Bazar. The objective of these consultations is to ensure the inclusion of Rohingya perspectives within the response, inform operational actors, and make recommendations to relevant stakeholders. Accurate understanding of Rohingya perspectives related to health guidance and the wider response is critical in mitigating the transmission of the virus and ensuring that the response is reflective of Rohingya's particular socio-cultural needs. In this, *COVID-19 Explained* will also include any misinformation or "flying news" regarding the response but focus more broadly on stated perceptions surrounding COVID-19. Several future editions are planned to thematically explore various issues that will likely arise surrounding the response. For more information or suggestions regarding future editions, please contact ACAPS or IOM.

Methodology: The information in this report reflects the findings of 19 (FGDs) and 6 (KIIs) across nine camps (10, 16, 20, 20ext, 22, 23, 24, 25) from 15th to the 19th of March. These consultations were conducted by a team of 15 experienced Rohingya field researchers (7 females and 8 males) that have been trained in qualitative research methods by IOM's CwC programme under Site Management. They are supported by four Bengali CwC staff with a high degree of English and Rohingya language fluency and two international researchers experienced in qualitative data collection. This report is part of a series of reports on perceptions of the COVID-19 response, led by IOM's CwC team in collaboration with ACAPS. Data is collected by IOM and jointly analyzed with the Rohingya volunteers themselves. Interviews are recorded with consent and transcribed by Rohingya volunteers and Bengali staff. Data is then analyzed with qualitative data analysis software and through matrices. Findings are discussed with volunteers during weekly meetings and their interviews are included as part of the dataset.

Limitations: The information outlined in this report does not represent the official views of the International Organization for Migration (IOM) or ACAPS in Bangladesh, it reflects an analysis of the views of Rohingya refugees living in camps in Cox's Bazar. It should also not be read as a definitive or comprehensive account of the Rohingya's perceptions on Coronavirus or COVID-19 across all camps, and it is likely to adapt as the circumstances change and as more consultations are conducted. The data is not representative of every camp context but should be taken as representative for different key demographics within the population and across the camps.

Additionally, in the analysis below, a greater focus was given to consultations conducted by Rohingya enumerators over those conducted by CwC staff and Site Management because the latter were included in the initial 'Flying News about Corona Virus Bulletin' published on 18th March [\[here\]](#). By focusing on the data collected by the Rohingya enumerators the perceptions held in Teknaf camps are not as extensively represented in comparison to those in Ukihya as all consultations in forenamed Teknaf camps were conducted by either Site Management staff.

Sources of information

As reflected in the "Flying News" report on 18th of March, primary information sources on COVID-19 for Rohingya are informal networks on WhatsApp and social media forums, followed by NGOs and Mosques, Imams and religious officials. It should be noted there are differences between "sources of information"



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and information disseminators. Internet, news, information from NGOs and radio are believed to be sources of information about the virus, whereas religious officials are often involved in the dissemination of information and the interpretation of the virus within religious norms. Some people also report trusting information provided by NGOs, but it is largely unclear whether trusted information is the same as information that is generally adhered to as guidance. With respect to behavioural patterns, information from humanitarian agencies are undoubtedly secondary to religious leaders and other community figures.

"We have a request from you. We fled here from Myanmar. We used to access network here earlier, so we were able to watch news about us, communicate with our relatives who are in Myanmar. But now, the situation is big and there are big matters happening all over the world each day. We need to know or hear what is happening, what the Coronavirus is, and what is going on around the world, but we cannot due to the lack of internet access..."

Male FGD, Camp 20 extension

"We came to know about Coronavirus from radio and R-vision news." (Male FGD, Camp 16)

"Mostly we trust from radio and TV information. And we also trust in your information because you have come from the source (of NGOs) but we don't believe in the news which we hear from shops and markets." (Male FGD, Camp 10)

"As in camp we couldn't watch TV news due to a lack of network, we can only get information from the persons who are listening to the Radio. So, we trust the radio programs which announces the right information -- BBC Myanmar [in Burmese] and Voice of America." (Male FGD, Camp 16)

"Our trustful source are mobile phone and news." (Female FGD, Camp 20)

There is a general consensus among all interviewed that information and awareness about Coronavirus will help to prevent its spread and protect their families. There is an overwhelming desire to know more about the virus and to receive information from official sources. Of the 25 consultations, 20 raised outstanding questions and requested more information on COVID-19. The majority of these questions centered around treatments and ways to protect their families.

"Yes, it is very important for us to know how we can prevent ourselves from getting the virus and how to cure ourselves when someone gets the virus. My family is vulnerable so how can I get money for treatment if we are infected by the virus. We must prevent ourselves from becoming infected." (Female FGD, Camp 20)

"We have learned the information about hygiene promotion from the meetings that are carried out by NGOs but they explain about Coronavirus to us. We are only hearing rumors about it" (Female FGD, Camp 10)



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When asked about rumours, all consultations reported hearing different rumours surrounding the virus, some highlighting that they find it difficult to identify which information is factual and which is not. During six separate consultations, respondents explained that due to the internet ban they are forced to rely on rumors and unreliable sources of information.

“Everything we are hearing is rumours because we have no access to information” (Male FGD, Camp 20 ext.).

Volunteers reported that during data collection it was clear that areas of the camp with less access to internet relied more on rumours and had lower general awareness surrounding COVID-19. Access to information is a critical need for Rohingya in the camps during the COVID-19 response. Already in initial discussions surrounding isolation and treatment options, communication is being stressed as a key condition for anyone who is requested to isolate.

General perceptions of the virus

All respondents across the 25 consultations believe that COVID-19 is deadlier and far more dangerous than the virus’ actual fatality rate. The perception that the virus is fatal increases the fear and stigma associated with being infected. Only one focus group mentioned that they had heard of people recovering from the virus. This is counter-productive to efforts that encourage people to follow health guidance, including reporting symptoms, seeking testing, and isolating. This needs to be addressed through comprehensive awareness programs that fully brief the Rohingya on the impact of the virus, fatality rates, symptoms and treatment options.

*“We heard that if the virus infects anyone then there is no chance to stay alive anymore.”
(Male FGD, Camp 10)*

“We hear that it is dangerous and fatal disease. According to what people are saying, if a person is infected with it, he dies.” (Male FGD, Camp 10)

“We have heard many flying news. I heard that three people died in Balukhali and more died in Takingkhali because of Coronavirus.” (Female FGD, Camp 20)

Though prevention strategies and common symptoms of infection were cited by many participants, no one could correctly identify which symptoms were more likely to occur in COVID-19 infection or their impact. There were also a range of symptoms not related to Coronavirus reported alongside the major identified symptoms and it is clear that messaging surrounding symptoms is being “mixed” with other messaging surrounding other illnesses.

Causes of infection and beliefs surrounding prevention

In 22 of 25 consultations, participants were able to name recommended preventative measures as per existing guidelines. There is common knowledge that general cleanliness, hand washing with soap, social distancing, and avoiding coughing or sneezing near others are generally important. However, the understanding of the logic behind these preventative measures is weak and the failure to understand why they prevent the virus from spreading means that their importance is also misunderstood.



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Rohingya generally rely on a cultural understanding that illness comes from dirty conditions, dust, and garbage. The word for virus is the same as the word for germ and insect – with germs sometimes being referred to as “small fuk.” This means that they are sometimes conflated when discussing health related issues. As a result, the understanding of how the virus spreads (through respiratory droplets that enter the mouth, eyes, and nose) is poorly understood. In discussions it is unclear whether people believe that it is a microscopic virus a small insect, or a bacteria that poses a risk to them. Often the presence of insects is conflated with the presence of the virus or other diseases in ways that suggest the source of illness is often confused. Further confusions arising from this term are evident.

My brother told to my mother that “In china, a person coughed and did handshake in day and when he slept at night, a fuk [virus, germ, insect] came and bit that person and the four of them immediately died. they are adults and they don’t have parents. Maybe they were bitten from nose or mouth or hands. We did not see but it is in internet. We heard that Chinese people gave this fuk to bite them. Maybe they did this to kill them.”

“We must keep our children safe. We must stop them from playing with garbage.” (Male FGD, Camp 10)

“It spreads through old food and uncleanliness. The fuk is a new and serious disease which is caused by Allah’s decree as no disease is arises without the will of Allah. There are some fuk of disease inside the human body. So, when I talk with someone face to face, then if the air of exhalation from my mouth reached into your nose, you will also get the same disease.” (Male FGD, Camp 20 ext.)

“If someone has urinated, and if another person pees over that urine then there are possibilities to transmit diseases from the urine.” (Male FGD, Camp 20 ext.)

“It occurs through the dirtiness. For example, if some water is stored in a place, and it gets bad by the pollution, some fuk are formed and animated from this bad water. Those fuk will come on your food and also when you open your mouth, the fuk enter it, and it becomes a disease by reaching in the stomach.” (Male FGD, Camp 20 ext.)

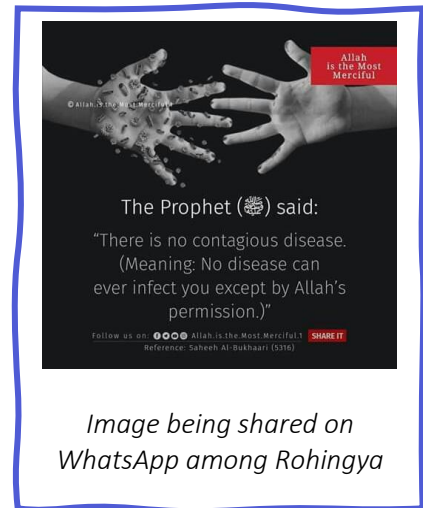
While the main prevention messages were understood, there were problems with the understanding of preventative measures versus treatment. Some people were confused over whether hand washing was a preventative measure or treatment and others were confused about why shaking hands would prevent transmission while other contact would be less likely to do so. Some pointed out the impracticality of implementing the guidelines because of the congestion and scarce resources available in the camps, which is not acknowledged in the current official messaging. For example, there was no information about how Rohingya were supposed to use tissues when these aren’t being provided to them or wash their hands when they have insufficient access to water. This leads people to rely on folk remedies and other preventative measures that were identified and discussed in greater details in the earlier “Flying News” report.

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“Eating one onion before breakfast each day can prevent from Coronavirus” (Male FGD, Camp 20 ext.).

Religious guidance on prevention

For many Rohingya, Allah’s will and their practice of Islam are intertwined with their susceptibility to the virus. Throughout consultations, Allah was mentioned 96 times in 16 consultations. Most people believed that it was “Allah’s will” whether they got the virus or not. Some also suggested that the disease was the result of a lack of adherence to Islamic norms and practices. It is important to realize that simply saying otherwise is not going to change this belief. Rohingya religious traditions have been a key coping strategy historically that have allowed them to deal with disasters, political persecution and other hardships. Rohingya will rely on these beliefs and practices through the COVID-19 crisis and humanitarians need to develop more nuanced approaches to engage with religious beliefs that capitalize on transforming interpretations instead of replacing existing value systems.



“According to Quraan and Hadith, Almighty Allah sometimes give punishment with a strong disease to test when the people are not obeying Allah's instructions. So, I think Coronavirus is endowed by nature to have test in people minds that Allah is only one. Allah disapproves of us and that’s why Allah sent it. There is no one who can send this virus except Allah.” (Male FGD, Camp 16)

“All things are happened by Allah instructions. We can't do anything. If Allah wants it, all of us will die in this place or we will be alive for 60 more years.” (Male FGD, Camp 10)

“It’s a punishment from Allah. Its Allah’s will to give this.” (Female FGD, Camp 20)

“This is not virus. This is the punishment of Allah for those who are committing human rights violation and torturing innocent people and not working for the justice of the innocent. Now, every corner of the world has atrocities, so I have to say that this punishment for that.” (Male FGD, Camp 21)

“We cannot predict this as it happens according to the verdict of Allah. If people would know who are at risk, then those patients would be admitted for the treatment by the families to the doctors. There are so many countries where sex is so common – why are those people not getting any of these diseases! As this world is not for the true Muslims, it is for non-Muslims. If Muslims commit bad things like sex out of marriage, theft, burglary, extortion of vulnerable people, fraud, transgressions or use drugs, then Allah will not be happy with these transgressions. Then these kinds of diseases will appear, and no physicians or specialist can do anything.” (Male FGD, Camp 20 ext.)

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There is also a widely held perception that by following strict religious practice and guidance that Allah will protect them from this virus. Religious beliefs regarding the virus are heavily influenced by Deobandi schools of thought that emphasize a person's faith and piety as the cause behind good and ill fortunes. In following religious norms people also believe that they will protect themselves from infection. The dissemination of Islamic prayers and blessings (*du'a*) is now commonplace across the camps as a way for people to protect themselves from the virus. Here it is clear that while people may accept a wide range of preventative messaging, religious norms and practices may supersede other guidance. Furthermore, when preventative messaging clashes or interferes with religious practices and norms, Rohingya have reacted strongly and said that they would not follow such guidance because of their beliefs in the supremacy of Islamic teachings.

"The INGOs are prohibiting us from praying Namaz in the masjid. We are not going to listen to them. Whatever they will do we can't stop praying Namaz. We can prevent the Coronavirus by praying 5 times Namaz and Namaz is the treatment for all diseases. We had to listen their nonsense words because we are getting rations from them."

Elderly Rohingya Refugee

"If we follow the rule and regulation of almighty Allah and the instructions of Allah's messenger prophet, it will not be possible for Coronavirus to touch us." (Male FGD, Camp 16)

Perceptions of treatments

Among the 25 consultations conducted, there is no awareness of how the virus is treated or tested for, and a lack of clarity on how to identify infection and whether there is a vaccine. This supports the results that were discussed in the 18 March "Flying News" report, and the conclusion that there is a lack of general understanding of the virus and its impacts. The lack of official information on these topics directly impedes people's ability to dismiss the rumours and misinformation surrounding treatments of COVID-19.

Over half of those who were consulted (16 out of 25 consultations) are aware that if they believe they have contracted the virus they should seek medical advice, which is in line with the official COVID-19 messaging. However, no participants showed any understanding of the care that doctors would provide those infected or that the type of treatment provided will depend on each individual's severity of symptoms. There is also limited knowledge and various perceptions regarding whether or not there is a cure for the disease. The predominant perceptions expressed around a cure for COVID-19 were that the hospital will cure the disease (13 consultations), don't know (12 consultations), and there is no cure (10 consultations). Allah was also directly mentioned in some discussions as the cure, as well as, eating garlic, washing hands, praying, taking certain spices, and drinking water that contains pieces of coal which were dug up specifically from the right side of their front door.



Image being circulated on Whatsapp as evidence of vaccine



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“The rumour is that in Saudi Arabia a religious person saw it in dream that if anyone digging in the right side of the front door of his own house, he/she can get coal and put it water and drink it. If he/she does this, they will be cured from COVID-19” (reported by IOM SM Staff member in Camp 25 where people have done this)

“An NGO told us to wash our hands frequently with soap and to use tissue when we cough but they didn't tell us that what should we do when someone is infected.” (Male FGD, Camp 21)

“We think they will do something like vaccinate us. When there was diphtheria this is what they did and it works.” (Mixed FGD, Camp 18)

Though there were many consultations in which participants mentioned they would take a suspected case of COVID-19 to the hospital, there are alarming rumours circulating that the authorities will be required to kill anyone who is infected to stop the spread. This perception was identified in three of the nine camps where consultations took place.

“Interviewer: What would you do if you or someone in your family had symptoms of Coronavirus?”

Participant 1: I will not go anywhere, and I will not share that with anyone.

Interviewer: Why?”

Participant 1: Because I heard that two people were shot in Chittagong because they had Coronavirus.

Participant 2: Nowadays, doctors in the clinics are avoiding us and they said the virus will transfer to them from us.” (Male FGD, Camp 16)

“If anyone gets infected, the authority has to kill him/her. Because if he stays alive, his virus will transfer to another person's body.” (Male FGD, Camp 20)

Due to the level of fear surrounding the virus and the perceived high fatality rate, it is predicted that bed rest, fluids and paracetamol will be met with confusion and frustration. There is already a general perception that such treatment is insufficient in meeting health needs, as the majority of households often seek additional and alternative health care outside of the camps (MSNA 10/19).

“We go to hospitals for treatment but generally always we get the same medicine like paracetamol. But I know that the medicines or treatment of Corona are really different.” (Male FGD, Camp 20 extension)

We go for one whole day to get 2 paracetamol at some health posts. We call these places ‘paracetamol centres.’ They should be closed because they aren't providing real services.” (FGD with male CwC volunteers)

Perceptions of those infected or thought to be infected

Over half of those who were consulted (18 of 25 FGDs) are aware the virus originated from China, and many understood that it was spreading around the world by those who had travelled. Interestingly, the consultations conducted by Rohingya field researchers (as opposed to IOM CwC staff) were more likely to



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discuss the origins of the virus (12 out of 13 consultations), and only consultations conducted by Rohingya enumerators uncovered the perception held by some that foreigners and/or those who are not Muslim are more likely to be infected by the virus. Response bias is clear based on who is spoken to and who is consulting the population.

“People are telling not mix with bezati (non-Muslims), not to do comings and goings, not to go near to them and to avoid them.” (Female KII, Camp 20 ext.)

“After spending time with my foreign friend who works in the camps my family told me to go wash as foreigners could be infected with the virus.” (Female Rohingya CwC Volunteer)

The consultations conducted by CwC staff and Site Management revealed that those who display suspected symptoms of COVID-19 are also stigmatized. However, upon review of the wider dataset it seems that while people are unwilling to go report their symptoms at health centres, stigmatization of those infected and the belief that they need to be killed is more ambiguous than previously identified.

“I would lock my friend in a separate room [if they had symptoms] as long as he has symptoms and pass him food over the door.” (Male volunteers)

“Someone had a headache, and everyone wouldn’t let him near them. They were shouting at him to stay far away.” (Mixed FGD, Camp 18)

“We have to tie-up the infected persons or we have to lock him in an empty room.” (Mixed FGD, Camp 18)

Though these alarming perceptions were not held by the majority of respondents messaging to combat stigma and address those more severe perceptions should be a priority. While the belief that the infected should be killed is in a minority of respondents and consultations, the perception that they will be killed by health care providers or government officials is strong – likely due to previous histories with authority figures and low levels of trust in existing providers. Anti-stigmatization messaging is still necessary to normalize the disease, symptoms and the virus and may work well since many people identified the symptoms as very common:

How can we know if someone has Corona virus just from symptoms. These are normal symptoms so we really don’t know. (Male CwC volunteers).

Perceptions of the most at-risk groups:

During the consultations, when asked “who do you think is more at risk,” responses varied greatly with some explaining that “everyone is at risk,” while others had heard that women, children and the elderly were at a greater risk. Will yet others identifying foreigners or bezati (non-Muslims) as the most at risk most likely because of the belief that they will “bring the virus to the camps.” Such variation in response suggests a lack of consistent understanding of the virus and illnesses in general, particularly how it is transmitted and the difference between bacterial vs. viral infections.



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“Children always stay outside of shelter and they are used to touching soil and other waste materials which may contain bacteria or Coronavirus.” (Male FGD, Camp 20)

As the vast majority of people consulted believe that the virus is extremely deadly and that survival is unlikely, the majority interpreted the open discussion question as who is most at risk of contracting the virus (who has greater exposure) while very few identified that some individuals might be more affected by the virus than others.

“All kinds of people children, old men, adults can get Coronavirus. Everyone, if I get virus, he will get. If he gets virus, then other will get it.” (Female FGD, Camp 20 ext.)

I'm am very afraid because people are saying that Coronavirus mostly affect to women and children. (Female FGD, Camp 21)

Perceptions of humanitarian response

Though all respondents that were engaged in consultations greatly appreciated the key COVID-19 prevention messages that were played at the end of the discussions, as well as those that they may have received beforehand, many expressed concerns about their ability to implement the main guidance, especially those focused on social distancing, increased hand washing and hygiene. Many explained that the conditions in the overcrowded camps, the public water and hygiene infrastructure and their lack of access to essential NFIs such a soap, masks, tissues and cleaning materials make the guidance almost impossible to follow. In nearly half of the consultations, participants expressed their concerns with the conditions and the way in which some humanitarian programs are currently conducted which impact their ability to follow the COVID-19 prevention messages.

Some respondents are upset with some of the preventative behaviour change messaging that have been provided so far, especially regarding religious gatherings. Many are worried about the capacity of the health clinics in the camps and whether they will be able to provide treatment if they contract COVID-19. The pre-existing distrust in health care providers within the camps combined with programming changes in response to COVID-19 is already causing confusion.

“INGOs are telling to wash our hands and to drink more water but we don't have enough water and we have to go far away as only one water supplier exists per block. So, we would like to request you to ask from INGOs to provide us more water supplier.” (Female FGD)

“We heard that INGOs will stop working in the camp for two months and we are worrying what we will eat if we will not get rations and if anyone among us has disease where will we go to get the cure. We are very anxious about this. This will be a very big challenge rather than Coronavirus for us as we are relying on INGOs. People seem very worried and upset.” (Female FGD)

“Workers are even not giving the food tokens hand to hand to Rohingya Refugee because they think the virus will transfer from the Rohingya. Rohingya are feeling that they were humiliated.” (Female FGD)



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“We went to a health clinic and the health post staff were yelling rudely at Rohingya to stay out of the health post because if we are sick we will spread the illness among us. This is causing panic and stigma.” (Mixed FGD with volunteers, different camps)

“If we go to clinic they don’t accept us. The hospital is good. But if we don’t have a fever they don’t accept us. They say ‘you have no fever’ and tell us to go.” (Female KII)

“In camps, there is no big hospital. If anyone of us want to go outside for the treatment, we should have to take permission from camp authority. I think if anyone of us has Coronavirus, when we try to go outside for the treatment by the time we should have to die in camp as it takes long time to get permission.” (Male FGD)

Conclusion & Way Forward

This report hopefully reveals the extent to which the humanitarian community needs to work more closely with Rohingya refugees to better understand and engage them in ways that build trust and mutual understanding. Top-down communication that seeks to “replace what people know” and fails to consider the underlying logic and values surrounding “why people think this way in the first place” will be ineffective at creating behaviour change in accordance with relevant health guidance. Before, these problems were a wide-spread response issue reducing the quality of humanitarian assistance – now they are critical obstacle in saving livings and ensuring the transmission of the virus is reduced. This is not an easy task even without a potential impending epidemic in the camps. *COVID-19 Explained* will support these efforts by continuing to conduct a series of consultations that will result in operational recommendations surrounding the following topics. Additional information can be sought as the dataset grows and questions can be incorporated into future works based on agencies’ needs. Please contact the *Covid-19 Explained* team if you have suggestions or information needs surrounding Rohingya perspectives. Consultations will be completed and disseminated as soon as sufficient data is collected for analysis.

Future topics for exploration:

- What do Rohingya think are essential and non-essential services?
- Religious beliefs surrounding COVID-19 and how to engage them
- Understanding Rohingya’s isolation related needs
- Women & Girls’ reported experiences of COVID-19 and it’s impact on their lives