

ROHINGYA RESPONSE

Health behaviours & COVID-19

The 855,000 Rohingya Refugees currently residing in 34 makeshift camps in Cox's Bazar, Bangladesh are highly vulnerable to COVID-19. Lessons learned from previous epidemic responses, such as the response to Ebola across affected African countries, highlight the critical role perceptions have on health seeking behaviour, trust in humanitarian responders and the willingness of affected communities to comply with public health measures.

Among the Rohingya refugees in Bangladesh, distrust and lack of confidence in the medical system of the response is widespread. The implications of this on the effectiveness of any COVID-19 response cannot be overstated or ignored. The perception that the Rohingya have of the health system in the camps is their reality and is highly informed by their culture, history, and their understanding of sickness and health. Their decisions about how to behave in an outbreak will be shaped entirely by that reality and this is the reality that is already shaping their uptake of preventative measures. Therefore, if the perceptions and opinions of Rohingya on healthcare are not taken properly into account and if community awareness and engagement are not prioritized as a key pillar of the COVID-19 response, lessons indicate that the capacity of response actors to control the outbreak will be severely hindered. Rohingya must be engaged and informed throughout all stages of the programming cycle to build trust. At a time when humanitarian staff are facing access challenges and reduced activities in the camps, proactively engaging Rohingya will also help to ensure overall programme continuity while building the trust and engagement desperately needed to implement effective COVID-19 control measures.

The purpose of this thematic report on health behaviours is to support humanitarian responders in understanding the current perceptions of healthcare, the impact of these perceptions on health seeking behaviour and the direct implications these perceptions and behaviours have on the ability to respond to, and control, a COVID-19 outbreak in the Rohingya refugee camps.

PERCEPTIONS of HEALTHCARE



Influences on seeking health care for COVID-19 symptoms –

- Official messages
- Past experiences
- Rumours & stories
- Trust



Experience at health facilities can be good or bad!

😊 POSITIVE

- Communication is clear
- Treatment is explained
- Conduct is respectful

Trust increases

- More protective measures used
- More health seeking

☹️ NEGATIVE

- Poor/no communication
- Treatment is not explained
- Conduct appears disrespectful

Trust decreases

- Less protective measures used
- Less health seeking
- More alternative health care
- Limited knowledge of case numbers
- Increased (belief in) dangerous rumours



If people are not given information that answers their questions, they will find other answers.
WORD SPREADS QUICKLY



INCREASED LIKELIHOOD of CONTAINMENT
INCREASED CAPACITY to TREAT CASES that do ARISE



LESS LIKELIHOOD of CONTAINMENT
MORE CASES. MORE DEATHS.

PERCEPTIONS versus INFORMATION

COMMUNICATION

CONSEQUENCES

IMPACT

Key findings:

1 Negative perceptions around healthcare and distrust of responders is already impacting COVID-19 preparedness efforts.

2 Knowledge of symptoms and public health messages (e.g. washing hands, social distancing) is insufficient to ensure behaviour change.

3 One-way community awareness and messaging is not a replacement for community engagement in preparedness. The most effective medium to convey behavioural change messages are Rohingya themselves.

Methodology

This thematic report presents an analysis of publicly available secondary data. It brings together lessons learnt from past epidemics, and examines current health seeking behaviours and perceptions of health care among the Rohingya, in light of the COVID-19 pandemic. Perceptions included in report are collected by IOM's CwC team, which includes Rohingya field researchers during a weekly awareness and data collection exercises. The report presents an analysis of the potential impact of these perceptions on a COVID-19 outbreak, as well as provides recommendations for mitigation.

Limitations

This report relies on publicly available sources and analyses data at a response wide level; therefore, should be used only to provide a contextual overview. In order to inform activity level preparedness planning more detailed location-based information is required, as well as insights from sector leaders and other operational actors.

Executive summary

According to the Institute of Epidemiology, Disease Control and Research (IEDCR) there are currently 54 confirmed cases of COVID-19 and five related deaths in Bangladesh (WHO 30/03/20). Though official numbers are low, due to global shortages of testing kits and the variation in severity of symptoms, case numbers, and the extent of the virus' spread is likely to be vastly underreported (WHO 19/03/20). As of publication, there has been one confirmed case of COVID-19 in Cox's Bazar city, approximately 50 kms from the camps. However, due to high population density, poor hygiene, insufficient health facilities, inability to self-isolate within the camps, and predicted higher than average transmission rate, the risk of infection is high (see ACAPS COVID-19 Risk Report 20/03/20).

Humanitarian agencies and the Government of Bangladesh (GoB) have begun rapidly implementing preventative measures, and preparedness and response planning is underway for a COVID-19 outbreak. The focus has been on prevention and preparedness through increased hygiene facilities, public health and awareness messages, development and implementation of business contingency plans, reduction of non-essential staff and programs, and the scale up of health facilities, capacity and personnel. According to the latest ISCG SitRep, planning is underway to prepare an initial 1,500 beds across Cox's Bazar district in treatment facilities with the capacity to isolate. WHO and the Health Sector are mapping existing supplies and identifying urgent procurement needs and medical staff capacity (ISCG 25/03/20). Large-scale risk communication has been identified as a major priority, with the development of a Risk Communication Technical Working Group and the COVID-19 Risk Communication and Community Engagement Strategy (RCCE 16/03/2020).

Current health seeking behaviour

It is well documented that the health services provided by humanitarian agencies in the camps are generally viewed negatively by Rohingya with high levels of distrust and scepticism about quality. Despite having access to free healthcare, every response-wide quantitative or qualitative study confirms that Rohingya households prefer paid health services, available outside of the camps. The baseline relationship that Rohingya are found to have with the healthcare system in the camps is characterized by a lack of trust. Four main factors contribute to this: **overloaded healthcare system in camps; confidence in alternative health care services; communication and accountability between health staff and patients; and experiences from Myanmar.**

Lessons learnt from Ebola responses in Africa

Lessons from Ebola responses in African West Africa and DRC provide important insight into actions that can be taken immediately in the Rohingya context to minimize morbidity

and mortality in a COVID-19 outbreak. Three key factors have been consistently identified as making the 2014-16 West Africa Ebola outbreak so difficult to control: weak health systems, high levels of poverty and a lack of trust in authorities, which translated into a lack compliance with control measures and lack of trust in health care providers. In particular, this report unpacks the following as key lessons to be applied:

- The necessity of clear, honest and targeted messaging and engagement of affected community to build understanding and combat harmful rumours;
- Critical role of positive patient-provider interactions;
- Requirements for familiarity and explanation of key facilities required to treat the virus in order to ensure people trust them;
- Behaviour of health workers can reinforce negative perceptions, reducing health seeking behaviour and compliance with preventative measures.

Impact of unaddressed negative health perceptions

Pre-existing negative perceptions around healthcare are already impacting attitudes and perceptions around COVID-19. Current, qualitative research reveals feelings of confusion, tension and distrust towards health services and reservations surrounding service providers' capacity to provide adequate care during a COVID-19 outbreak are widespread. These perceptions have the potential to negatively impact efforts to contain an outbreak among a highly vulnerable population.

Major concerns in the context of lessons learned from Ebola already identified include:

- Filling information gaps with rumours and experiences from social connections is already fuelling panic and sowing distrust in advised containment measures.
- COVID-19 preparedness measures, response plans and their impact on camp health services are unfamiliar to Rohingya, have led to confusion and tension.
- Changes in the camps are already reportedly impacting non-COVID-19 related health seeking behaviour and access to services.
- Due to a lack of understanding and familiarity with proposed isolation measures, initial data from 12 FGDs across seven camps suggests Rohingya are unlikely to comply with those measures.

Summary of recommendations

- Proactive measures to address fears and misperceptions that are likely negatively impact COVID-19 control and response efforts must be prioritized.
- Bottom-up communication aimed at alleviating mistrust and improving community knowledge and perception of COVID-19 should be pursued.

- Positive health seeking behaviour should be capitalised upon, by ensuring those who attend health facilities have positive experiences.
- Increase transparency and accountability at health facilities from the bottom-up by engaging Rohingya community leaders and other community representatives in the monitoring of these services.

Current health seeking behaviour

While efforts to scale up health capacity in the Rohingya refugee camps are ongoing, there are currently 154 basic health units, 41 health centres (open 24/7) and five hospitals operating across the 34 camps. These health facilities are free of charge, and open for Rohingya to use (ISCG 12/19). Despite having access to free healthcare, every response-wide quantitative or qualitative study confirms that Rohingya households prefer paid health services, available outside of the camps, and will take on debt in order to access it (MSNA 10/19, WFP REVA2 05/2019, UNHCR 11/19). Good healthcare is as important to Rohingya as it is to people all across the world. They display strong health-seeking behaviour, and will pursue the care they deem appropriate, whether they can afford it or not.

The 2019 Joint Multi-Sector Needs Assessment (MSNA) 97% of individuals who required medical treatment sought assistance and that 4 out of 5 of those households reportedly visiting NGO run health clinics (MSNA 10/19). However, despite this, 80% of households who required medical support engaged in coping mechanisms to meet their health needs, and of those households 66% report incurring a debt to pay for private health services outside the camps (MSNA 10/2019). As of October 2019, a cumulative 47% of households spent 1001-5000 BDT (12-60 USD approx.) on health care and 5% of households report spending more than 5000 BDT (MSNA 10/2019). Private clinics (29%), pharmacies in the markets (22%) and government clinics (8%) were found to be common sources of medical treatment outside of health clinics in the camps (MSNA 10/2019). This pattern of seeking additional, or alternative, paid healthcare, when free health care is readily provided, strongly suggests that Rohingya either do not trust the health care they are receiving in the camps, or do not perceive it to be adequate to meet their needs (MSNA 10/19, UNHCR 11/19).

Underlying factors driving health seeking behaviour

It is well documented that the health services provided by humanitarian agencies in the camps are generally viewed negatively by Rohingya with high levels of distrust and scepticism about quality. This is what leads people to buy additional medication in the market or seek alternate treatments in private clinics (MSNA 10/2019, UNHCR 11/2019, WFP

REVA2 05/2019, IOM 02/20). These perceptions are not minor complaints of dissatisfaction, but they are a major part of household decision making that leads to harmful coping strategies, as outlined above, that will adversely impact humanitarian outcomes. The perception of health care is of critical importance right now as the response prepares for a COVID-19 public health emergency.

Rohingya's dissatisfaction with available health services is well documented; however, the contributing factors to these perceptions are not. Health seeking behaviour among Rohingya has not been extensively researched. However, based on studies focused on service access and needs, and household economy more broadly, four leading factors emerge as major contributors to Rohingya's health seeking behaviour: **overloaded healthcare systems, confidence in alternative health services outside the camps, communication between health staff and patients, and experiences in Myanmar.**

Overloaded healthcare system in camps

According to the Joint Response Plan for 2020, health facilities are unable to meet current caseloads. In particular, there is inadequate capacity and resources for non-communicable disease management, laboratory diagnostics, mental health and psychosocial support services, among others (JRP 2020). As a result, patients who go to the camp health facility are often referred to government hospitals and private clinics.

The inadequacy of health services in terms of quantity and quality is even more prominent for individuals with mobility challenges, such as those with a physical disability, chronic illness, and the elderly who face access challenges arising from discrimination and exclusion, and inaccessibility in a terrain with steep hills (UNHCR 2018, ADH, CDD, ASB 2017, Humanity & Inclusion 01/2019, MSNA 10/19)

Some studies, such as the Refugee Influx Emergency Vulnerability Assessment (REVA), surmises that this contributes to the overall perception that the health clinics in the camps are not equipped to meet Rohingya's health needs (WFP 05/2019). It also increases confidence in outside health care providers such as government hospitals and private clinics which have the capacity to offer more services.

Confidence in alternative health care services

WFP's REVA 2 found that the increased confidence in health services available from government hospitals tends to discourage those with serious disease, requiring a referral to outside hospitals and clinics, from visiting camp health centres at all (WFP REVA 2 05/2019). Feedback received from Rohingya community members has also indicated that private clinics have passed judgement on advice or treatment provided by doctors in camp health clinics.

"We don't trust the medical diagnosis in the camps because when we go to doctors outside the camp they criticize what we were prescribed. My sister was prescribed

calcium and it damaged her kidney; the doctor outside the camps said that it was because the prescription was wrong.” (IOM CwC 03/2020)

Whether or not this is widespread practice, or merely a rumour, stories such as this are common, and spread easily through the community, contributing to the view that camp health care is poor.

Communication and accountability between health staff and patients

Most Rohingya believe that camp health facilities distribute only paracetamol, regardless of the diagnosis. This perception has been noted in all forenamed research and is one of the most cited criticisms provided by Rohingya when explaining the inadequacy of the health clinics and why they prefer to pay for health care (MSNA 10/2019, UNHCR 11/2019, WFP REVA 2 05/2019, IOM 02/20, ACAPS 12/2019). The REVA 2 explains that, in reality, most health centres are supplied with, and distribute, various antibiotics, though not packaged in a way to differentiate them visually from paracetamol. **This suggests that a lack of communication between health care professionals and patients regarding what is being prescribed, and why, is fueling this perception of inadequate treatment** and driving Rohingya to take on debt in seeking alternative healthcare.

Significant feedback has been received from Rohingya, complaining about lack of explanation provided, and difficulty understanding medical staff. The vast majority of communication in the camps is conducted in Bangla or Chittagonian dialect. Though Chittagonian shares many similarities with Rohingya, the languages are different. Translators Without Borders (TWB) found that 36% of refugees have difficulty understanding basic Chittagonian (TWB 11/2018), making misunderstandings common, and presenting particular challenges for those who are monolingual (TWB 11/2018).

Rohingya frequently report feeling disrespected by health workers, leading them to believe that health workers in the camps do not have their best interests at heart (MSNA 10/2019, ACAPS 12/2019, IOM 03/20)

“We are not happy with the hospital because they are busy with their phones and talking together, so we have to wait for a long time and after that they give us only paracetamol, no matter what the disease.” Female participant, Camp 17 (ACAPS 12/2019)

In addition, as the health care services that are provided are free, many Rohingya report feeling as though they lack the power and adequate accountability mechanisms to demand improved services which also contribute to their increase use of outside services and lack of trust in health care clinics in the camps.

Experiences in Myanmar

The lack of communication and understanding around the health system in the camps has meant that expectations that of what adequate health care looks like, for most, is shaped by their experience with health care in Rakhine.

People report being more satisfied with health care when they get a tangible sense of being valued, when treatment is explained, or when techniques and treatments they consider more medically valid are used. For example, FGD participants in often spoke of preferring injections they were accustomed to getting in Myanmar, and feeling happy about being checked “with the machine” at health posts (ACAPS, 12/2019),

“We need good medical facilities and doctor facilities. Good medicine and injection must be provided by them except paracetamol.” Female FGD, Camp 3 (IOM CwC 03/2020)

A Rohingya field researcher for IOM’s CwC unit explained that the referral system is not common in Myanmar, where people go directly to the doctor that specialises in the illness they have. Visiting a single doctor for all illnesses, only to be referred to another doctor may explain households’ inclination to ‘cut out the middleman’ and interpret this as health clinics’ inability to provide adequate health care on site (ACAPS, IOM 03/20).

In addition, the government sanctioned prosecution that the Rohingya population endured while in Myanmar which included killings, disappearances, torture and other inhumane treatment, rape and other forms of sexual violence and arbitrary detention gravely impacts upon their trust in authorities (UNCHR 2018). Rohingya people were continuedly prosecuted and denied many basic rights including citizenship, freedom of movement, access to healthcare and education, marital registration rights and voting rights (UNHCR 2018). The restricted access to formal health services including public hospitals and government clinics as a result of long-standing discrimination and travel restrictions meant that Rohingya had to often seek out alternative traditional practices such as homemade medicinal remedies, or seek advice from traditional healers, herbalists, shopkeepers who stock medicines, and faith or religious healers (UNHCR 2018).

Applying lessons learnt from Ebola responses in Africa

The importance of the impact of community perceptions on health seeking behaviour during an epidemic has emerged as one of the most significant lessons learned through continued resurgence of Ebola across western and central Africa. Three key factors have been consistently identified as making the 2014-16 West Africa Ebola outbreak so difficult to control: weak health systems, high levels of poverty and a lack of trust in authorities, which translated into a lack compliance with control measures and lack of trust in health care providers (ACAPS 02/2016). MSF’s Ebola Emergency Response in West

Africa operational review identified improved communication and awareness, and improved community engagement as two of the top ten components of an effective Ebola response (Coltart, Cordelia E M et al. 2017). In general, a lack of communication, awareness and community engagement translated into limited public knowledge of the disease, triggering misinformation, rumours and panic. This fear had a detrimental effect on service usage (ACAPS 02/2016).

These are trends already observed among the Rohingya. Pre-outbreak, their lack of trust in health services already impacts their use of the health services provided. **Currently the limited public knowledge of COVID-19 has led to a number of harmful rumours, and panic. If not properly, and swiftly, addressed the likelihood of repeating the mistakes of Ebola responses remain high.** The key learning from Ebola responses relevant to health seeking behaviour relevant to the responses' ability to manage and treat COVID-19 in the Rohingya refugee camps, are outlined below.

In the absence of targeted messaging and engagement, perceptions of Ebola were determined by close social connections

A World Bank study reviewing the impact of community perceptions and experiences on the control of Ebola in the Democratic Republic of Congo (DRC) in 2019 found that participants' understanding of Ebola was based on the reported experience of a relative, friend or neighbour who had been infected, or in contact, with the virus. Their perception of the symptoms, management and outcomes of these episodes in turn determined their level of trust in the medical response (World Bank 2019). For example, many participants to this study claimed that quarantine was either useless or a cause of death, explaining that the people they knew who had been quarantined had died (World Bank 2019). Insufficient official information regarding containment, treatment and expectations of the disease, as well as measures to combat it meant affected communities based their beliefs on the experiences of others and filled the gaps in their understanding with the scant information available (Nyenswah et al., 2015; Pellecchia, 2017; Pellecchia, Crestani, Decroo, Van Den Bergh, & Al-Kourdi, 2015). This contributed to the rumour in some locations that the vaccine was designed to eradicate a particular ethnic group (World Bank 2019).

However, negative perceptions can be reversed by the sharing of positive experiences, as documented by a 2015 study in Sierra Leone.

“At first, they were calling it ‘death center’ [Ebola treatment units] because all those who were taken there died. But now we are seeing them going there and coming out alive. Only those that are taken there late and in serious condition will lose their life” (Kambia—adult man, Sierra Leone, 2015) (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018).

Importance of patient–provider interactions

Personal interactions with health workers, and whether individual's felt they were being cared for on a personal level, has been identified as a major factor influencing trust in health facilities and health care workers (Karafillakis E, Jalloh MF, Nuriddin A, et al.11/2016, Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018). A study from Sierra Leone found that strict infection prevention and control measures (IPC) taken by health care workers in the early stages of the outbreak, which were unfamiliar to affected community members, impacted their expected level of personal interaction with health care workers, and may have contributed to misunderstanding and distrust among community members (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018). However, once the outbreak subsided, and stories from survivors circulated throughout the community, trust in health services improved.

Based on these findings, the research concludes that improved interpersonal communication skills of health workers are critical in fostering trust in the healthcare system. Additionally, developing patient–provider feedback mechanisms and communication tools that promote positive experiences of community members who directly interacted with health care systems will improve perceptions and promote or resort trust in the health system (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018).

Familiarity with key facilities required to contain and treat the virus

Perceptions of health services are also influenced by the physical environment of healthcare facilities and the resources used within those facilities (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018). It is commonly reported that during the outbreak in many Ebola affected areas that community members saw essential health facilities and resources as causes of death, rather than sources of recovery, as these facilities were unfamiliar and their immediate experiences illustrated a pattern of death among patients who interacted with those facilities (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018).

A fear of ambulances, because often sick people who went away in them did not return, was a major contributing factor to many not seeking immediate health support when required. A national household-based survey conducted in Sierra Leone found that almost one-third of participants 'did not intend to ride in an ambulance if sick' (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018). In response to this issue, responders in Port Loko and Kambia, Sierra Leone held 'ambulance exhibitions' which allowed members of the community, including leaders, to inspect the ambulances and judge for themselves that they were safe, clean and operated by professionals whose main role is to save lives. This successful community engagement strategy was recommended to be applied in other key healthcare facilities, such as clinics and isolation facilities (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018).

Fear of transmission decreases general health seeking behaviour

A major secondary impact resulting from the Ebola outbreak was the increase in preventable mortality and mobility of non-Ebola related illnesses, including maternal mortality, Malaria, HIV and TB, due to a decrease in clinic attendance and health seeking behaviour. Though this can be partly attributed to the reduction in health services because they had been diverted to treat Ebola patients – as will undoubtedly be the case with COVID-19 – fear of contracting Ebola and mistrust in health services making people reluctant to seek care has been cited as the main cause (Fitzpatrick G, Decroo T, Draguez B, et al. 2017, Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018). As a result, many Ebola affected countries witnessed an increase in reliance on alternative health providers (pharmacies, traditional healers and private practices), a trend which is already widespread among Rohingya.

Behaviour of health workers can reinforce negative perceptions, reducing health seeking behaviour and compliance with preventative measures

Fear of contracting Ebola among health workers led to the abandonment of many health care facilities and the refusal to treat those with Ebola like symptoms. This only increased pressure on already overburdened health care service and contributed to the public's lack of trust in health providers and a decrease in their overall health seeking behaviour (Fitzpatrick G, Decroo T, Draguez B, et al. 2017). One case of this was abandonment during the Ebola outbreak in Democratic Republic of Congo when all the healthcare workers of Kikwit General Hospital fled (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018). This phenomenon is not restricted to developing countries. In fact, a WHO survey of health care workers in the United States found that over half thought it was acceptable not to show up for work during the Avian Influenza outbreak (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018).

Conversely, inconsistent application of public health guidance by government and non-government responders at a personal level, such as failure to wash their hands regularly and practice social distancing, contributed to increased scepticism towards the disease. This scepticism fuelled rumours and conspiracies questioning the viruses' existence and led to refusal to follow essential public health guidance key to controlling the virus' spread (Nuriddin A, Jalloh MF, Meyer E, et al. 04/2018).

Impact of unaddressed negative health perceptions

The impact of pre-existing distrust in health facilities and personnel, combined with insufficient community engagement around COVID-19 is already evident in the camps. Regular consultations held by IOM's CwC team highlight the **uneven uptake of COVID-19 messaging among Rohingya, an inability to dismiss rumours and false information and an overwhelming lack of confidence in health facilities and reservations in humanitarian agencies' capacity and willingness to support them in this time of crisis** (IOM, CwC 02/04/2020).¹ Despite no questions being asked about health care or health facilities directly, participants in 20 out of 37 consultations across 14 camps in the past two weeks expressed concerns about the capacity and conduct of health professionals and facilities in the camps. This indicates a widespread distrust and lack of confidence in camp healthcare, fueled by poor patient-provider relations.

Key lessons learnt from Ebola responses which highlight the criticality of perceptions, especially regarding healthcare, indicate that left unaddressed the current environment has the potential to drastically impact the COVID-19 related mortality and morbidity, as well as the secondary health impacts resulting from decreased health-seeking behaviour.

Recent field research demonstrates that many of the negative experiences, interactions and perceptions that led to Ebola proving so challenging to contain in West Africa and DRC are mirrored in the Rohingya context.

1. Filling information gaps with rumours and experiences from social connections is already fuelling panic and sowing distrust in advised containment measures.

All participants across 37 consultations in 14 camps believe that COVID-19 is far more dangerous than the virus' actual fatality rate. The lack of reliable information available about the virus increases the fear and stigma associated with being infected. A particularly harmful and persistent rumour is that health services are killing patients suspected to have contracted COVID-19. This was mentioned in 15 consultations in 9 separate camps. This rumour, and others like it, combined with the Rohingya's baseline distrust of camp healthcare, have the potential to gravely impact Rohingya's willingness to comply with critical measures such as isolation and reporting of cases, and thereby responders' ability to track or contain the spread.

“They are telling us that if someone has it, the person has no chance to survive anymore and the person will kill by the authority.” Mixed FGD, Camp 21

¹ Tracking of community perceptions surrounding COVID-19 and the response has been ongoing since March 18, the results of which are published in a weekly series called COVID-19 Explained.

“We heard that if the virus infects anyone then there is no chance to stay alive anymore.” (Male FGD, Camp 10) “We are also hearing that the doctors disappear and kill the patients whom they find the virus in. In this situation, if the patients with cough and cold visit clinics, then the doctors even don’t see these kinds of patients.” Male FGD, Camp 3

“We are concerned about it. We are getting a lot of flying news. People are being killed, shoot down with gun. People are burned down. That is why we are worried. We are afraid of losing our lives before it lost naturally.” Male FGD, Camp 1W

“The patient are avoiding to go hospital, they heard that if someone gets positive coronavirus, the doctor gave die injection to patient and everyone are worrying about it.” Female FGD, Camp 4

“The virus still doesn’t come in the camp. And we feel afraid because we are so close to each other’s. And we may die when it touches us. And we are worrying that if we are admitted to the clinics, they may kill us.” Mixed FGD, Camp 4

2. COVID-19 preparedness measures, response plans and their impact on camp health services are unfamiliar to Rohingya, and have lead to confusion and tension.

Reports of conflicting messages, hostility, and treatment refusal at health facilities are such sources of confusion and tension. Participants in all 37 consultations across 14 camps said they were unaware of COVID-19 treatment processes and many consultations mentioned that despite following public health messaging they were met with conflicting messages upon arrival at health clinics.

“In the hospital they are asking us to stay far away. They are yelling at us. More than before. Their Joban (language) is bad. I don’t like to go there. Their communication is bad.” Male FDG, Camp 1W

“Yesterday I went to hospital. All the doctors were maintaining huge distance and they were not talking to us also. They were telling to buy medicines from outside and telling us to go outside of the hospital.” Female FGD, Camp 3

“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. The health posts also aren’t even given paracetamol recently. We don’t know why this is and we think it’s because of the virus.” Mixed FGD with volunteers from various camps across Ukhiya

“The doctors in the camp also don’t use instruments like thermometers and other tools. How can they tell what is wrong with us? We don’t know how they test for coronavirus. I heard that a university [name has been removed from notes] has put

their students in 14-day quarantine and gave them all azithromycin for the virus.” Female FGD, Camp 1E

3. Changes in the camps are already reportedly impacting non-COVID-19 related health seeking behaviour and access to services.

FGD participants reported being turned away at health clinics for treatment of non-COVID-19 related illness or symptoms. The also reported being afraid to go to clinics because it would increase their risk of infection. At the same time there are also reports that private clinic fees for general health check-ups have drastically increased.

“Yesterday I went for the treatment of diabetes, but they discontinued my treatment. They just provide treatment to the serious patients.” Female FGD, Camp 3

“If we got to clinic they don’t accept us. The hospital is good. But if they don’t get fever they don’t accept. They told us you have no fever and tell us to go.” Male FGD, Camp 20 Ext.

“Sometimes we have to go to hospital out of the camp. My son got jaundice. Doctors from Chittagong advised to take medicine for 3 months uninterrupted. But after two months medicine is finished, and I can’t go out of the camp. And for the diseases like diabetes or jaundice the clinic does not provide treatment.” Male FGD, Camp 1W

4. Due to a lack of understanding and familiarity with proposed isolation measures, initial data from 12 FGDs across seven camps suggests Rohingya are unlikely to comply with those measures.

Despite Rohingya understanding and expressing their support towards the intention of the proposed containment measures, they have expressed strong reservations to complying without what they believe to be adequate explanation and familiarisation with the facilities.

“We need to get information about isolation, where is it and who will take to go to isolation or take proper care of us. We need to know.” Female FGD, Camp 4

“Another thing is when someone take into isolation, we worry that they[doctor] will kill the patient” Female FGD, Camp 19

“In the camp, some people are afraid to go there [isolation] because they will be not cared with treatment and killed there. But Some people don’t like that. They think that they will get proper treatment there.” Male, FGD, Camp 16

“If a person is infected, then one of his or her relatives have to accompany to the isolation. The doctors must take him or her with protective ways from spreading. There have to be a caretaker with the patient. It will not be safe for the patient going there alone. They cannot believe where the patient has gone.” Male FGD, Camp 3

Recommendations for COVID-19 response

- ❖ **Proactive measures to pre-emptively address fears and misperceptions** that are likely negatively impact COVID-19 control and response efforts, such as isolation facilities, disease fatality and treatment options, are essential and must be prioritized.
- ❖ **Bottom-up communication aimed at alleviating mistrust and improving community knowledge and perception of COVID-19 are essential.** One-way messaging is insufficient to ensure behaviour change or build trust in response and containment strategies and capacities. Rohingya themselves should be mobilized to engage proactively in the design and implementation of risk mitigation and risk communication activities. At this time when humanitarian staff are facing limits on their activities in the camps, proactively engaging Rohingya to fill some of those crucial roles could have a positive impact, not just on programme continuity, but also on building trust and engagement desperately needed to implement effective COVID-19 control measures.
- ❖ **Positive health seeking behaviour should be capitalised upon**, by ensuring those who attend health facilities have positive experiences. This will begin to change the narrative regarding camp healthcare among the Rohingya.
- ❖ **Increase transparency and accountability at health facilities from the bottom-up** by engaging Rohingya community leaders and other community representatives in the monitoring of these services. This will enable Rohingya to develop trust in the clinics and give them agency to contribute to improvement of these services in ways that also consider their social, cultural and religious practices.



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- Conduct appears disrespectful



Trust decreases

- Less protective measures used
- Less health seeking
- More alternative health care
- Limited knowledge of case numbers
- Increased (belief in) dangerous rumours



LESS LIKELIHOOD of CONTAINMENT.
MORE CASES.
MORE DEATHS.

PERCEPTIONS
versus

INFORMATION

COMMUNICATION

CONSEQUENCES

IMPACT