

## No Isolation without Consultation

Edition #3, 9 April 2020

### Executive summary

This week's consultations focused on perspectives of isolation and "shielding" plans currently under discussion within the response. While Health Sector has yet to finalize plans for shielding and isolation facilities, consultations were held to determine what factors and logic will impact people's decision to engage in these plans more generally.<sup>1</sup> **Rohingyas' wider acceptance of health**

**interventions is equally as important as health intervention themselves and there is an urgent need to consider "community acceptance" as an intrinsic part of health intervention programming.** Last week [Edition 2](#) of COVID-19 Explained showed that failure to consult Rohingya on decisions about COVID-19 have already negatively impacted their trust in humanitarians and there is a significant risk that trust may be further eroded if and when isolation and shielding plans are implemented without discussion and consultation with Rohingya.

*"Why would I go to the prison [shielding facility] if I am not sick. I heard from people that doctors are taking the patients and killing them." (Camp 20ext, women)*

*"We only have one mask per household and we can only go out one at a time because otherwise the police will hit or arrest us. Because of this, we are sharing masks with our neighbours but the masks aren't being washed. Maybe this will cause more problems." (Field Notes 5.3.20)*

It was repeatedly noted by Rohingya that "everyone will not have the same opinion" on whether to isolate or engage in shielding plans. Rather, it is important to consider the range of concerns and requests from Rohingya as co-dependent factors in their decision to isolate or shield. This consultation seeks to outline these factors, general perspectives of these terms and highlight "sticking points" for people in their consideration of these options. No one factor will affect everyone's decision to

engage in these plans and decisions will change over time as information and context shifts. While it is understood that not all demands can feasibly be met, it should be noted that plans and decisions must be discussed with the Rohingya population as part of the process of gaining acceptance. **Many have expressed their willingness to compromise and change their behaviours, but only if they are engaged to do so by humanitarians and trusted members of their community.** This is will not occur through message dissemination but rather a proactive strategy of relationship and trust building.

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<sup>1</sup> Shielding is defined by Health Sector (draft definitions) as the voluntary and temporary relocation of the most vulnerable to a residential facility to protect them from community transmission during an outbreak.



## Key findings:

### Overall thoughts on isolation and shielding:

- **Helplessness, despair, and fatalism are a reflection of honest considerations about Rohingya's own conditions and capacity to adhere to healthcare guidance.** Many people reflected on the space required for adequate isolation facilities, the cramped conditions of the camps, the sanitation and other factors as insurmountable to prevent the transmission of the illness. These viewpoints need to be engaged and discussed if people are to be encouraged to isolate or shield.
- **Among people who believe the disease is communicable, there is understanding that isolation is a necessary approach to prevent the virus from spreading.** A minority of camp residents believe that the transmission of the disease is subject to the "will of Allah" and that isolation matters less than a person's piety and adherence to Islamic norms and traditions.
- **However, even people who saw themselves as personally vulnerable to COVID-19 were unconvinced by shielding plans, though some showed willingness.** Initial discussions show that even people who self-identified as vulnerable to COVID-19 and were told they could request any facilities were uninterested in the option. Many of these people also didn't understand why they should "shield" if they weren't sick. This could be because of the belief that the disease is not transmittable or because they did not want to be separated from their families. For those interested, there were clear requirements for them to be willing to participate.
- **There is a lack of understanding about what constitutes "isolation" and a difference between the medical understanding of isolation and the Rohingya's.** Most consultations revealed that people demanded a caretaker accompany them during isolation for "protection." Some people specifically referred to "protection from being killed" by health care providers. Other people reported that they would isolate alone but the majority expected to be accompanied by a family member.

### Requirements of isolation and shielding facilities:

- **First and foremost, Rohingya wanted medical professionals and proper treatment in isolation facilities.** In particular, Rohingya requested foreign doctors and Rohingya volunteers at medical facilities because they were more trusted. Rohingya volunteers were requested to help with communication with healthcare professionals because many Rohingya don't understand the doctors.
- **Consistent responses to both isolation and shielding were that people do not want to be separate from their families.** For shielding, people wanted to be able to see and speak with their families from afar and the majority of refugees preferred localized isolation within their camps and blocks. People even requested support to isolate within their shelters.
- **In addition, continuous communication with family members is a key requirement for everyone.** People said they would want to be able to speak to their family members over the phone; some specifying via video call to be sure that they are okay.
- **Food needs should not be underestimated at these facilities.** People expected to be well taken care of with sufficient access to foods they deem nutritious and useful for preventing illnesses. This includes



# COVID-19 Explained

ensuring access to foods like meat, spices, and fish. People are unlikely to shield or isolate if the quality of their conditions is lower than what they normally have access to.

- **NFIs such as mosquito nets, prayer mats, lighting and other basic services were also desired.** This was reported important for ensuring people felt safe and comfortable enough to stay in shielding or isolation facilities for the necessary time period.
- **Materials and facilities required for religious practice were also important to people.** People mentioned the need for prayer mats, prayer spaces, place for recitation of Quran and support in following dietary restrictions, as shielded people are not sick and will practice Ramadan normally.

## Gender consideration for isolation and shielding:

- **Gender segregation was a demand by all men and women.** The thought of non-gender segregated rooms was unacceptable to everyone. The gender of the staff working in those facilities must also be considered. Many people will not accept non-segregated isolation or shielding facilities or allow women and girls to go to such facilities.
- **Most women mentioned that they can't be separated from their children. Women mentioned that they will need to isolate with their children if they are sick or that they would be unable to shield or go into isolation because they had children to care for.** This highlights specific gendered needs of shielding and isolation plans that limit and prohibit women from taking certain protective measures because of their main role as caretaker. Women understood the risk this entailed and resultingly requested proper protective equipment to keep themselves safe while caring for sick children or vulnerable family members.<sup>2</sup>

*"Explanation is better than treatment, if before going into the isolation, they should explain about it very well."  
(Camp 4, Female)*

## Recommendations:

- **Immediately discuss and refine proposed definitions and details of plans with Rohingya refugee women and men in order to determine the wider acceptability and show Rohingya that humanitarians are actively engaging with their concerns.** Consultations regarding these plans should be held by people the Rohingya report to trust in order to elicit honest responses. Given concerns and reports for how Rohingya are treated at health care facilities, this probably means staff not associated with these facilities. Consultations need to occur more broadly and in each camp with religious leaders, community leaders (women and men), CSOs and the general population.
- **Low trust with health care providers can be addressed now by implementing stricter codes of conducts about how Rohingya are treated and spoken to at facilities.** People reported "the need for Rohingya volunteers" to be present at facilities because they could not understand doctors, who were less likely to speak even Chittagonian, because they were afraid of being killed, and because of their previous experiences of being disrespected in these spaces.

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<sup>2</sup> Noting that gender was not extensively investigated in this edition, this will be covered in an upcoming version of the series.



## Introduction

Isolation was discussed in 16 focus group discussions (FGDs) with Rohingya living across camps in Ukhiya Upazila of Cox's Bazar between the 24th of March and 8th of April in preparation for the eventuality that containment and contact tracing will be implemented in the event of a COVID-19 outbreak. While detailed plans have yet to be finalized, consultations were held to determine what factors would impact people's decision to participate in these interventions. To determine the specific acceptance of any plan, full, detailed information would need to be provided and responses gauged. It is important to consider that within Rohingya culture, people are unlikely to directly say "no" to many plans and instead emphasize voluntariness of plans or alternatives they prefer as a rejection. People's perspectives are also likely to remain subject to change as the response develops and cases begin to be reported in the camps and nearby vicinities. Similar to other disasters and extreme weather events, experience from Site Management says that Rohingya in the camps are unlikely to take action until there is a clear and immediate danger. For example, despite advanced warnings of extreme rain or wind events, many Rohingya will refuse to temporarily relocate until after water levels have risen even if there is advance warning. The situation is likely to be similar in the COVID-19 response, with Rohingya initially unlikely to seek treatment, isolate, or shield in early stages when confirmed cases have yet to be reported in their specific camps.

**Methodology:** The information in this report reflects the findings of 16 FGDs (8 female, 7 male, and 1 mixed) between participants 20-60 years of age across camps (1W, 1E, 3, 4, 5, 16, 19, 20, 20ext.) from 24th to the 8th of April 2020. The first 12 of these consultations were conducted by a team of 15 experienced Rohingya field researchers (7 females, 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. In light of the rapidly evolving response planning, additional perception data on both isolation and "shielding" was collected through 4 additional FGDs (2 female and 2 male) in Camp 20 and Camp 20 extension by IOM's CwC team. Data is collected by IOM and jointly analysed with the Rohingya volunteers themselves. Interviews are recorded with consent and transcribed by Rohingya volunteers and Bengali staff. Data is then analysed with qualitative data analysis software through matrices. Findings are discussed with volunteers during weekly meetings and their interviews are included as part of the dataset. General information and answers to questions were provided to participants following the focus group discussions. This report is one in a series on perceptions of the COVID-19 response led by IOM's CwC team in collaboration with ACAPS.

**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 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. Teknaf camps were not able to be reached by field researchers due to the volunteers being based in Kutupalong Balukhali Expansion; therefore, the data is not representative of the Teknaf refugee population. Additionally, the information on "shielding" was only covered by 4 FGDs and therefore should be taken as an initial investigation into the topic. **More consultations with detailed information are needed to inform shielding plans and consultations should engage in people who are trained to elicit perspectives from Rohingya in trusted and safe spaces.**



# COVID-19 Explained

## Understanding isolation as a concept

All participants in the 16 consultations understood the importance of isolation as a technique to contain the spread of the virus, with many citing that they are familiar with this process from the diphtheria outbreak that occurred at the end of 2017. Generally speaking, many people who were consulted are in favour of taking action to prevent harm from coming to others in their family and community. **This means that humanitarians and Rohingya have common ground to discuss and build an operational response plans;** however, there are key requirements that Rohingya stress must be met, and issues that need to be discussed and resolved.

*“It will be very grateful and mercy for us from Allah if they keep us in the isolations. Because it is better to die one person instead of dying many people. So, it will be better if we can put the patient to isolation.” (Camp 5, Female)*

*“We strongly agree with that because there was occurring a new disease called diphtheria as soon as we arrived here. For that disease, the MSF has built tent health-post at a garden in Bhalukali-2. If someone used to get mumps, then the patient used to carried and kept there until they recovered. Now, it will be good for our people if they build and prepare isolated places for the coronavirus. We are agreeing if they keep us there separately. We are thinking and feeling panic that if the coronavirus comes in this camp, no NGO in the world can stop it as we are over-populated here.” (Camp 16, Male)*

*“As we understand, if someone is infected of coronavirus, then it transmits to another person. If it transmits, we have to keep the infected person isolated. If we keep isolated, then we have to give that person rice, meals and take bath. Then, we have to touch them during these moments. But how can we keep that person isolated here as we do not have space for this... We are staying in shelters of 14 feet and 10 feet. I have eight family members at such size of shelter... We can't keep them isolated in our shelter, we can keep that person on the roof by fastening with ropes if we want the infected to be separated.”*

*“There is no extra place in our shelter to keep him/her for the isolation. As the shelter is limited, where should we keep? There is only one solution. We should bury him/her alive.”*

*Camp 16, Male FGD – Note the above were said sarcastically because Rohingya are aware of the impossibility of their predicament and inability to isolate or social distance themselves given the congestion within the camps.*

Regardless of this awareness, all participants stressed that their compliance hinges on whether important conditions are met. **All participants stressed that they would only be willing to go into isolation after receiving adequate explanation and consultation about the facilities.** Details concerning isolation facilities will need to be provided before an understanding about their wider acceptance within a community can



# COVID-19 Explained

be gauged. Additionally, participants in 13 out of 16 consultations explained that no one would go on their own to isolation facilities, that at least one family member must accompany them. This is potentially a key issue that may not be possible within current plans for isolation facilities and needs to be immediately considered. Participants in 13 out of the 16 consultations also stressed the need to be able to communicate with family members outside of the isolation facilities via mobile phones.

*“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.” (Camp 4, Mixed)*

*“Parents have to go with the patients so that they can observe that their child is treated well.” (Camp 3, Female)*

*“If it is different place, then some may not want to go. Because we heard that the infected will be killed by “Cross Fire” (Camp 3, Female)*

*“While I am in isolation room, I would need to have all the human needs such as foods, clothes, soap, water, and so on. And I need a person who will look after me... The caretaker would be from a member of family and relatives.” (Camp 16, Male)*

*“There should be a corridor or a separate place from where the relatives can come and see their son, father or mother physically. Because always communication over phone call is not satisfactory.” (Camp 20, Males)*

*“If my child is sick, how can I stay away! I will have to go and serve my child first then will consider about the virus.” (Camp 20ext, Female)*

The primary reasons cited for needing a caretaker to “protect” them is the risk of being killed by medical staff. This clearly indicates the widespread perception that such practices are commonplace at health facilities, at the very least with respect to COVID-19 outbreaks. While this distrust is partially due to historical experiences of discrimination in Myanmar, it has also been contributed to by responders in the camps who are reported to have not treated the Rohingya patients with respect and dignity (see [ACAPS Health Behaviours & COVID-19 report](#)).

*“In the isolation, first we need to have network access. While we were in Myanmar, they persecuted a lot but they didn’t shutdown internet but now Bangladesh government did it and this is a big persecution for us. When someone dies we can't give any update to other relatives. If internet access is available, we can the patient in the isolation through video chat. Second, we need food, proper food assistance there and better treatment the patients must be respected. They have to show sympathy to us. The patient should be in peace. This is the most important thing in the world.” (Camp 4, Female)*



# COVID-19 Explained

To illustrate this point, participants in 12 out of the 16 consultations explicitly expressed fears of being killed by authorities while in isolation and that the risk of this occurring would increase if there was no relative or Rohingya acquaintance there to protect those who were required to go into isolation.

*“If a person is infected, then one of their relatives has to accompany them during isolation. The doctors must take them with protective measures to stop the virus from spreading. There has to be a caretaker with the patient. It will not be safe for the patient to go there alone. They can’t believe where the patient has gone.”  
(Camp 3, Male)*

*“If a person is infected, then one of their relatives has to accompany them during isolation. The doctors must take them with protective measures to stop the virus from spreading. There has to be a caretaker with the patient. It will not be safe for the patient to go there alone. They can’t believe where the patient has gone.” (Camp 3, Male)*

*“When someone take into isolation, we worry that [doctor] will kill the patient. That’s why they should allow to take one person with the patient for safety.” (Camp 19, Female)*

*“Some people are scared that we will be killed or will not be treated well but some people agree to go into isolation.” (Camp 16, Male)*

*“They should give update to us daily and they should get a contact number too to let us get updates. And can do with communication with family and relatives. There should be a relative to give security to patient otherwise the family members will feel uncomfortable and they may think the patient will kill. For example, my son will take into isolation, I will be worried if I don’t know where my son is being taking and what is going on with him and whether my son will feel comfortable.” (Camp 19, Male)*

*“If [isolation facility] is in a different place, then some may not want to go. Because we heard that the infected will be killed by crossfire” (Camp 3, Female)*

## Duration of stay & location of isolation sites

When discussing broadly the possible length of isolation, the vast majority of participants in the consultations (10 out of 12) expressed that the time spent in isolation, unlike the key conditions discussed above, was not a major determining factor in their willingness to go into isolation. **Many believe that if key conditions are met, then remaining in isolation 14 days or longer would not be a problem.**

*“We think it is good to be there not only fourteen days. The patients have to stay there for one month if necessary. The patients have to stay there until the recovery. We think it is good to be a mother or bother as a caretaker with the patient there in the isolation. We support that.” (Camp 3, Male)*



# COVID-19 Explained

*“Yes, people will go there not only for 14 days but also they will go for one months if there will be proper treatment.” (Camp 4, Female)*

*“No matter how long, we have to go to be good or avoid the virus. How long ever we have to stay 14 days or 3 weeks or even one month, we agree to become better because we don’t want to die. And if I get the disease, I have to go to the isolations for the safety of the other people.” (Camp 5, Female)*

With respect to where isolation facilities will be located, many people preferred that facilities be closer to, or within, the camps because it would allow them to know exactly where their relatives are. This is in line with the feeling that the more they know about where isolated family members are, the safer they will be. Few people felt that the proximity of isolation facilities would create a transmission risk.

*“If agencies could build one more extra room beside the current shelter so that we can keep the infected person in that room it would be good. As coronavirus is a serious virus and it’s spread from each other, it will be better if agencies can build isolation room in the camps that have extra place too.” (Camp 16, Male)*

*“If it is possible, please make a place near the isolation or shielding facility from where the close relatives can see them and can see their condition. Because in the previous week, a young boy was died. When he was sick, we sent him to the hospital in the camps. They referred him to Cox’s Bazar. After few days, his dead body arrive here. We didn’t see how he died. So, if you arrange that type of facility, then it will be very good for us.” (Camp 20 ext. Male)*

## What other things would Rohingya want while in isolation?

As well as general thoughts around the execution of isolation, participants in the 12 consultations were asked to think about the most important things that they would want to bring with them, and the type of support they would need, if they were to go to isolation.

Top things that were mentioned outside of the basic life sustaining essentials of food and water were:

- 1. Good quality medical care with many stressing the need for not only tangible medical treatment but caring interactions between patient and medical staff.**

*“For the moment, we need doctors who have knowledge of coronavirus. The responsible person of hospital should be patient and have empathy.” (Camp 3, Male)*

- 2. Food that is satisfying. This implies that food that is “nutritious” according to Rohingya and suitable for sick people.**

*“In isolation we want good food also because it can boost the power of our body and we will be able to stay protected from the disease.” (Camp 3, Female)*



# COVID-19 Explained

3. Communication, including both mobile phones with internet to communicate with family members, as well as staff at the facility that can communicate in Rohingya language. Many suggested educated Rohingya volunteers should work in the isolation facilities to facilitate this communication.

*“We want to keep contact with our family and to see them with video calls. If so, we will become happy.” (Camp 5, Female)*

*We will need the Rohingya people to take care of us and give us food because we don't understand the Bangla language.” (Camp 4, Mixed)*

*To understand our feeling and our illness, we need Rohingya volunteers in the isolation because we don't understand Bangladeshi languages.” (Camp 4, Female)*

*Bengali people don't talk with us because they think we have virus but we don't, so. We need Rohingya people in the hospital. (Camp 5, Female)*

4. Physical protection, referring to the need for Rohingya ‘watchmen’ or volunteers at the facilities. This may have been due to concerns over GBV and other violence at the facilities.

*“Internet and medicines and good doctors. And we will need the watchmen for the night.” (Camp 4, Female)*

5. Personal protective equipment such as masks, protective clothing and soap for caretakers and patients.

*“Medicine is important not only for the patient but also for the person who will go to take care of the patients. And they should provide something to the caretaker to protect themselves. The patients should see their family members and the family members also needs protection from the disease.” (Camp 1W, Male)*

6. Clothes and other essential personal items, including mosquito nets, blankets, sheets, and prayer mats. Some of these could be brought and may not needed to be provided in some cases.

*“They will need to give things which they will need for peace like mat, mosquito net and clothes.” (Camp 20 ext. Female)*

*“I will take separate clothes for prayer, and other clean clothes so that I can maintain cleanliness.” (Camp 3, Female)*

7. Gender segregated facilities – particularly rooms for sleeping & staying in. No participants said that facilities should be gender-integrated or that women would be willing or allowed to enter mixed facilities. Preferably, caretakers and staff should also be of the same gender as patients.

*“Women have to stay in their place and men have to stay in their place. All of them have to maintain purdah. Otherwise it will be a great sin. I will not send my wife or daughter if there is no separate place for men and women.” (Camp 20 ext. Male)*



# COVID-19 Explained

*"[The space] needs to be separated for men and women even 3 seconds before death."  
(Camp 20 ext. Female)*

*"If women and men need to share the same place, then I will not send my mother, wife or daughter to that place. If men and women stay in the same room, then our mother or sisters will not feel comfortable. In our religion, women have to maintain purdah. If we do not maintain Allah's instructions and maintain veil properly, then Allah will give us punishment." (Camp 20 ext. Male)*

## 8. Items to allow people to continue their practice of religion while in isolation.

*"Quran, Mosala and prayer mat for the Namaaz and internet to keep communication. Only Allah can save us and no one else." (Camp 5, Female)*

*"I will take separate clothes for prayer, and other clean clothes so that I can maintain cleanliness." (Camp 3, Female)*

*"We need all the things which we use at our home. We need space for saying prayers and recitation. Prayer mats and Quran. We need lights to recite the Quran." (Camp 20 ext. Female)*

## Initial thoughts surrounding shielding

In total, four FGDs focused explicitly on exploring initial perceptions of shielding. This conversation was partially predicated by discussions surrounding isolation more generally and conversations revealed a blurring between the two concepts – with many people believing that shielding was something that took place after a vulnerable person showed symptoms. Many people who believed they were themselves susceptible to the disease, whether because of illness or age, were unwilling to accept that they should go into isolation, equating it with a prison sentence. It is important to note that many people refused the idea on the basis that they would not separate from their family – citing the traumatic journey to Bangladesh with their family as a key reason why.

*"Why would I go to the prison if I am not sick. I heard from people that doctors are taking the patients and killing them." (Camp 20 ext. Female)*

*"We must need to send them. But all the people are not same. If I have a big shelter or a separate place beside my house, then I can keep my mother or others of my family there. Because they may not want to go there. If CIC give us approval, then we will do that." (Camp 20, Male)*

Others had mixed views and thought that some might agree to be isolated whether because they were vulnerable or were concerned about their community. Many people stated that the elderly are less likely to spread the disease since they travelled less and instead pointed to young people as transmission vectors because they travelled around the camps more. This demonstrated a failure to differentiate between the concepts of shielding and isolation despite substantial explanation from facilitators.



# COVID-19 Explained

*“We must send them. If anyone does not want to go, then our community leaders like – Imam or Majhi should make them understand about the importance of that facility.” (Camp 20, Male)*

*“Few will agree to go and few will not agree to go. Suppose, we are four here, we have different mind, I don’t know what is going on her mind and you don’t know mine. If we all were same, we could say that we all go. We must go to keep safe ourselves.” (Camp 20 ext. Female)*

People also had specific recommendations for shielding facilities that were similar or matching to those required for isolation facilities. These may not be in line with existing plans within Health Sector and need to be engaged if shielding plans are to be widely accepted. In particular, this included the importance of family-caretakers, food, basic facilities, gender segregated rooms, access to communications and visitation from a distance.

*“We will allow for his betterment. Another person must go with him. It can be a son or a brother. Because, the person will have to give us update about how the elderly man is.” (Camp 20ext. Female)*

*“We should allow them but they should not be moved from one centre to other without their relative’s approval because we are watching in internet that people are killed and sent to a separate island.” (Camp 20 ext. Male)*

*“There should be a corridor or a separate place from where the relatives can come and physically see their son, father or mother. Because only communication over phone calls is not satisfactory. If I see my father or brother it is good, then I feel good.” (Camp 20 ext. Male)*

## Questions & messages to share with humanitarian responders

At the end of the consultation, one of the closing questions posed to all participants was: *what do you want the humanitarian agencies to know right now?* This open-ended question allowed participants the opportunity to express their feelings and communicate something anonymously with no non-Rohingya humanitarians or agency staff present. The main messages and questions emerging are centred around the need for more information about the virus itself and how it is it detected and treated so households are more empowered to protect themselves and their family. People also wanted to know more about what is being done by agencies to protect them, with many highlighting the need for more medical staff, protective equipment, NFIs and income support. **Many people were keen to discuss and know more about shielding and isolation plans and reported “this was the first time someone has come to discuss Coronavirus with them.”** Many also stressed the difficulties they face implementing some of the preventative measures that they have been told to implement such as social distancing, staying in their shelters in the heat, and not being able to afford to buy masks for their family. Several participants across the FGDs also took this opportunity to communicate their high level of stress and feelings of hopeless surrounding the current situation.



# COVID-19 Explained

*"The free hospital is closed. If my children are feeling sick, where will we go for treatment? I can't go out because I have no income. I'm worrying over these things."*

*"My children can't go outside and are within my shelter, but here it is so hot. We have no fan and solar."*

*"We are homeless. Our brains are bad right now. We became mad after coming here. What will we understand... We are hearing that coronavirus is coming here and our brains stop running. We are doing only one thing: "Allah, Allah. Oh! Allah, save us. Oh! Allah! There is no one in the world except you, save us from coronavirus." And we hope that Allah will protect us."*

*"We have small children and we are concerned about food. We can't go anywhere by vehicle. Now, we can't go to work outside as we used to work before. We are facing difficulties to buy food. If we can't feed our children with some snacks then what will happen. If we have no foods and gas cylinders then how can we survive? Even the foods in market might be rotten and we won't be able to buy foods."*

*"We are always in tension. Rice doesn't go to our stomachs due to tension. One tension is that we had to leave from Myanmar. Now, it has been three years ago since we reached to Bangladesh. Our tension decreased a bit after such a long time but now increases again because of coronavirus. We are in tension all the time. We are doing many works to prevent coronavirus like cleaning, praying, and doing worship. We hope that Rohingya will not have coronavirus."*

*"The patients should be returned. Whether he would be recovered or died, they should be returned."*

*"Better to be buried in our homeland with our ancestors than in a foreign land where we cannot afford the land to be buried on."*

*"We want to know right now. The entire world is leaving other things behind and is only thinking about Coronavirus, how it spreads and where it has come from. So, those people should come somehow to explain and provide awareness to our people - how to stay protected, how it spreads, where it comes from. [Now] we do not have anything to stop that virus. The agencies and other NGOs discuss things like how the people get cured and how to destroy this virus. We want to get this kind of information from every NGO. We want the agencies to tell us that the virus is under control."*

*"My question is that as we are refugees, we want the NGOs that are helping refugees to make us aware of the ways to avoid this virus. For example, some people cannot buy masks to prevent this, we want those agencies to tell these people to buy masks and necessary items. As they can buy rice, then why they can't they buy masks that cost 50*



# COVID-19 Explained

*or 100 taka. Some people are saying why we need to buy mask and how will it benefit us and so many things. Those who are not smart are saying this. It will be good if the people of NGOs can explain to our people about these things and how to prevent it.”*

## Conclusion & way forward

If there is to be serious headway and acceptance on the current plans being developed for isolation and shielding, the lack of trust between Rohingya and healthcare providers must be urgently addressed. Some of the existing distrust is due to historical patterns and relationships over which camp healthcare providers have very little control, but there are things that can be done now to improve relationships and show that responders are actively engaging in people’s concerns. Since arriving in Bangladesh, Rohingya people have repeatedly pointed to their poor treatment at healthcare facilities and other service points in the camps as a key factor that harms their dignity, damages trust, creates confusion and weakens people’s desire to seek services.

Communication between healthcare professionals must be provided in an understandable language, either Rohingya or at least Chittagonian, and needs to be dignified and compassionate. If and when people become infected by COVID-19, they are more likely to rely on these services but that does not mean that mistrust and fear will not grow even more when patients die in healthcare. Trust building is the most effective rumour control. Community engagement and messaging needs to also consider how it can build trust and understanding instead of focusing solely on “messages” concerning COVID-19 rumours. Emphasis needs to be placed on the substantive nature of the relationship and interactions between humanitarians and Rohingya if trust is to be improved and traction made in combatting COVID-19.