

Different and Unequal

How COVID-19 affects different sex, age, ability and populations differently

Edition 5, 27th April 2020



This edition of COVID-19 Explained explores the differences in attitudes, knowledge and understanding of COVID-19 between key demographic groups. This data was gathered several weeks after the beginning of the ongoing COVID-19 awareness campaigns. For this edition, 42 interviews with women, girls, boys and men from Rohingya and host communities were conducted, including 9 interviews with people with disabilities, to gain a better understanding of how these dimensions result in different experience and impacts related to COVID-19 preparedness. It is hoped that this will help support nuanced communication strategies and programmatic consideration of affected populations' ages, genders, population groups and abilities. Based on this consultation, it is clear that everyone has been impacted significantly in different ways that will continue to come into focus as the response protracts.

Key Findings

- There are significant differences in terms of needs, access to information and impact of the COVID-19 response on different demographic, age, and ability groups among Rohingya and host community.
- Host communities report high levels of knowledge and understanding of COVID-19 but feel excluded from assistance. There are growing tensions between them and the Rohingya population as a result of the economic impacts of the COVID-19.
- Overall, Rohingya report good awareness of the main COVID-19 messages on transmission prevention but also desire more information and understanding of COVID-19 including treatment options. Rohingya adolescents and adult men display the best knowledge and understanding of the main COVID-19 messages of all Rohingya groups interviewed. There is still frustration about the feasibility of following some of the guidance (e.g. applying physical distancing in this context).
- Among Rohingya, older women, adult women, and people with disabilities report concerningly low access to information about COVID-19. Microphones, Tomtoms and other messaging taking place in camps is somewhat effective but limited in

reach to people with less access to public spaces, including women, older people, and people with disabilities.

- There is inadequate understanding of what treatments exist for COVID-19 and how these will help people. Only a minority of people, across demographics, had misconceptions or false ideas about treatments, despite many reporting to have heard various rumours about treatments. Generally, there was a belief that there is no treatments across all groups. This undermines reasons to seek assistance in people's understanding of COVID-19.
- Both Rohingya and host community are now reporting that they are more willing to go into isolation and seek treatment if infected. This is possibly due to the spread of the epidemic into Bangladesh and a result of the information dissemination campaigns. However, whether this reflects actual willingness to report symptoms is unclear. Rohingya participants are still consistently raising concerns of poor treatment and reduced provision of medical services persist. These concerns remain unaddressed and could have a major impact on their compliance with containment measures.
- Many participants across host and Rohingya communities express a willingness to isolate as long as there is gender segregation at the facilities and people of different religions are grouped together.
- Access to livelihood and employment opportunities as a result of the lockdown is having significant, negative impacts on food security and access to medical services for host community and Rohingya. Access to income was the most commonly reported concern of those consulted across all population and demographic groups. The disruptions on local economies and income generating activities have reportedly meant that Rohingya are unable to purchase food and meet their daily needs more than already was the case. For Rohingya, lower access to healthcare was also reported due to mobility restrictions and a decrease in earning to pay for private care.

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- Both host community and Rohingya women expressed challenges in accessing shared latrines during the day now that men are home all day as opposed to being at work for example, and struggle accessing adequate menstrual hygiene items.
- The reduction in income has also reportedly led to a spike in criminal activities and concerns over safety. This was a concern for both the host and Rohingya respondents who both gave examples of recent security-related incidents concerning crime & theft.
- Women and men are reporting higher instances of tension and violence against women within the household as a result of the lockdown, the amount of men spending time around homes, and the reduction in income.

Key Recommendations

- **Disseminate information on what treatment people are likely to receive if they contract COVID-19 along with more general information and updates about the epidemic, number of cases, and general information about the disease.** This was requested by all participants from all communities and groups. Greater knowledge and understanding of the virus will likely mitigate fears and improve health seeking behaviour. It is also important in addressing concerns over a lack of treatment and manage expectations if an epidemic in the camps occurs.
- **In terms of access to information, women, girls, people with disabilities and older groups need to be provided with targeted information campaigns tailored to the communication capacities and differential access to public spaces.** This edition has made clear the varying impacts each group is experiencing, and it is important that messaging be tailored to each group's communication styles, capacities, and limitations. Women and disabled people lack access to public spaces and public means of information dissemination. Disproportionate understanding of communication between demographics groups is clear evidence that current approaches are serving some groups more than others.
- **Urgently plan to mitigate socio-economic impacts.** Socio-economic impacts of the response need to be considered and addressed. With the re-opening of Bangladesh in different sectors, camp activities that provide income also need to be reopened e.g. expanding volunteer work and increasing payment. As much as possible, including Rohingya within the response has the added benefit of providing employment e.g. Rohingya volunteers in health facilities, engaging Rohingya in the production of masks etc. This will improve food security and reduce domestic violence.
- **Ensure that protection services are continued to mitigate GBV and support women & girls.** Women and girls are suffering disproportionately under the conditions of the

- lockdown. Having more people, particularly men, consistently around and in their shelters is further reducing their access to WASH facilities, increasing the likelihood of GBV.
- **Explore varying impacts further through additional consultations on specific groups of affected individuals, in particular the older people, people with disability, and women.** The impact of the COVID-19 response on older people, women and people with disabilities needs to be more extensively explored as these appear to be key groups that are being disproportionately impacted within the response. Within this study, they have been found to already be less likely to receive information and be impacted by measures such as lockdowns.
- **Advocacy efforts may also need to be increased to allow previously prohibited forms of programming, like cash transfers, given the limitations and restrictions on many income generating activities that were being conducted previously.**
- **Actions need to be taken to proactively communicate what is being done to support the host community and what safety nets exist for them during and throughout the crisis in order to prevent growing tensions and sense of disparity. Tensions existed and were growing before COVID-19 and are likely to continue to do so.**



Figure 1: The top 30 words used by participants when answering the hypothetical question “what would you do if you thought you had contracted COVID-19?”, and the follow up question of “who would you tell?” The majority of participants now report they would go to the hospital.

Methodology

It is well known that different demographic groups experience emergencies differently, have different opinions and have varying levels of access to information. Therefore, it is essential that these different experiences and perspectives are captured to inform agencies responding to COVID-19 to enable them to adjust their programming approaches. Using trained Rohingya field researchers from different locations in the camps, as well as CwC Bangladeshi staff for the host community, 42 qualitative interviews (15 FGDs and 27 KIIs) across 13 camps were conducted with specific demographics groups (refer to map pg. 3).

Table 1: Overview of total consultations

Population Group (total no. interviews)	Age Range	Gender	FGD (≥3 ind.)	KII (≤2 ind.)	Total
Rohingya (36)	Older people	Female	1	8	9
		Male	2	5	7
	Adult	Female	0	5	5
		Male	2	2	4
		mixed genders	0	1	1
	Under 18	Female	2	2	4
Male		2	4	6	
Host (5)	Older people	Female	1	0	1
		Male	1	0	1
	Adult	Female	0	0	0
		Male	1	0	1
	Under 18	Female	1	0	1
		Male	1	0	1
Mixed (1)	Adult	Male	1	0	1
Total:		Females - 20 Males - 21 Mixed - 1	15	27	42

The interviews used only open-ended discussion-based questions that were asked in the same way across demographic groups as much as possible under the same guidance. A mix between purposive sampling and convenience sampling was employed, purposive to ensure specific demographic groups were interviewed and convenience to comply with COVID-19 prevention measures and reduce risk of transmission. This meant that an even number of consultations were not conducted per camp or per demographic group (see limitations). All interviews conducted with 2 individuals or less were considered key informant interviews (KII) and all interviews with 3 or more people were considered focus group discussions (FGD), and the same questionnaire was used for both interview types. Table 1 provides an overview of all consultations conducted by population group (Rohingya and host community), age, gender, and type of consultations.

Persons with disabilities (PWDs) were identified through SMSD engagement with PwDs in Camp 18 and included people with both cognitive and physical impairments, caretakers of children with disabilities, and caretakers of older people with disabilities. See table 2 for the breakdown of the different demographics represented in the 9 consultations conducted with people with disabilities.

Additional demographic groups that can be identified are 3 KII conducted with Rohingya female head of households, and 1 FGD conducted with religious leaders from the host community and 1 KII with a Rohingya Imam. However, due to the small sample size the specific findings from these groups are not unpacked in detail separately.

Table 2: Consultations completed with people with disabilities (PWD)

Pop. group (total no. interviews)	Age Range	Gender	FGD	KII	Total
Rohingya (8)	Older people	Female	0	2	2
		Male	1	1	2
	Adult	Female	0	2*	2
		Male	1	1	2
Mixed (1)		Male	1	0	1
Total:		Females - 4 Males - 5	3	6	9
<i>*Conducted with caregiver and person with disability</i>					

Data collection was conducted between 6th and 15th of April 2020. Of the 36 consultations conducted with Rohingya, 23 were conducted by a team of 15 experienced Rohingya field researchers (7 females, 8 males) all of which have been trained in qualitative research methods by IOM’s CwC programme under Site Management Unit. The remaining were conducted by 2 of IOM’s Bengali CwC staff who possess a high degree of English and Rohingya language fluency. Remote support was provided by two international researchers experienced in qualitative data collection based in Cox’s Bazar. The 5 FGDs with host community were conducted by male, Bengali CwC staff in Teknaf.

Facilitators only interviewed respondents of their own gender. Data is collected by IOM and discussed with the Rohingya facilitators who conducted the interviews as part of the analysis. Interviews are recorded with consent, transcribed and checked by Rohingya volunteers and Bengali staff. Data was then analysed by ACAPS using 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 a part of a series on Rohingya’s perceptions of the COVID-19 response led by IOM’s CwC team in collaboration with ACAPS.

Due to the large qualitative sample size, authors have included numerical representations of discussions to show the frequency of occurrence of beliefs, knowledge and perspectives throughout the discussion. Over 120 pages of transcripts were collected to support the analysis in this edition. While larger statistical samples and quantitative studies may be preferred by some, it is believed that such approaches do not reveal the same level of detail or perspectives as elicited through this edition’s qualitative approach.

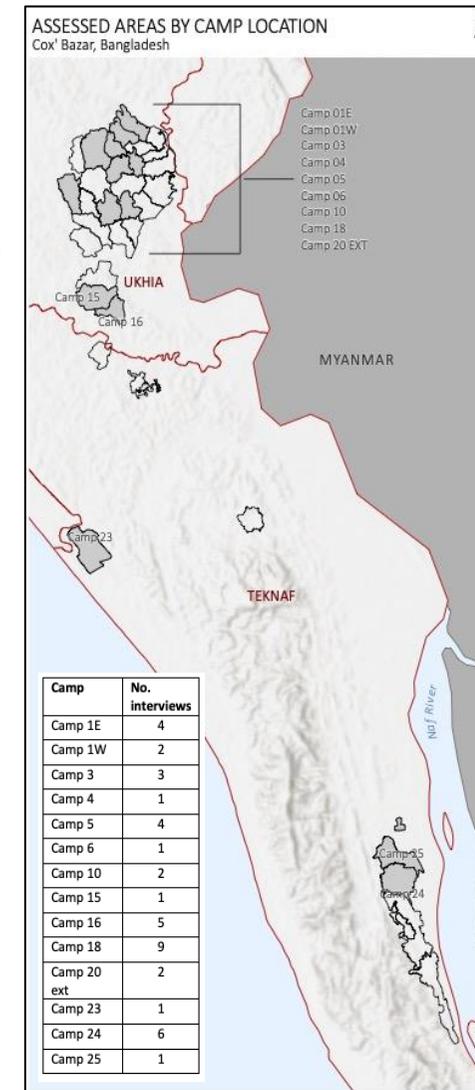
Data collection ethics during COVID-19: All staff have received training on how to protect themselves and those they are interviewing from undue risk of COVID-19 transmission. The use of trained Rohingya field researchers in the camps and Bangladeshi CwC staff from the host community enabled data to be collected face to face; however, strict physical distancing and hygiene rules were applied to ensure the safety of researchers and the participants. For this edition, a greater number of KIIs and more selective number of FGDs with people from already closely-knit social groups were conducted to minimize people’s interactions with others outside of their normal, immediate social group. Enumerators were asked to gather information in areas nearby their residence to reduce unnecessary travel.

Limitations

Different numbers of consultations were conducted between the demographic groups, under slightly different conditions with some conducted through KII and some FGD. Therefore, the results are not directly comparable; however, general observations can be made and discussed. Greater emphasis was placed on obtaining data from groups that are less frequently consulted. In addition, direct comparison between surveyed camp locations was not possible due to the different number of consultations conducted in each location and because not all demographic groups were surveyed in each location because of the movement restrictions in the camps faced by the Rohingya field researchers.

A greater sampling of the host community is needed to better represent and analyse differences between them and Rohingya or to conduct analyse of demographics within the host community. More work like this can be conducted and added to this dataset with sufficient time and interest, and depending on how the COVID-19 situation develops.

The minority of Rohingya and host community participants who practice religions other than Islam are not represented in the sample size. This was not done intentionally, given the mobility restrictions these groups were not able to be reached. However, future surveys will endeavour to remedy this gap. The information outlined in this report does not represent the official views of IOM or ACAPS in Bangladesh. It reflects an analysis of the views of Rohingya refugees living in camps and the host community in Teknaf. It should not be read as a definitive account of the Rohingya’s or host community perceptions on Coronavirus, the impact of their current needs across all camps, and it is likely to change with the circumstances and as more consultations are conducted.



Knowledge of COVID-19

Key findings:

- Host community FGDs with both men and women consistently displayed good levels of knowledge of official COVID-19 prevention measures.
- The qualitative consultations reveal that older Rohingya have the least knowledge pertaining to COVID-19, particularly older females. This was followed by women and girls more broadly, who were found to have slightly less knowledge than males within the same age range.
- Rohingya adult men and boys under 18 displayed a more comprehensive understanding of official prevention measures than other Rohingya groups.
- Based on the small sample size representing people with disabilities, it was observed that knowledge varied greatly between the 9 consultations – some had very limited knowledge while others had a good understanding.
- Hand washing and cleanliness messages have been received loud and clear, as well as social distancing but to a slightly lesser extent. People seem tired of hearing social distancing messages because of the difficulty of practicing this in the camps.
- The vast majority of people identified the older people and those with pre-existing illnesses as the most vulnerable to die from the virus, followed by children. There was no significant difference in this understanding between demographic groups.

Knowledge of prevention measures

When participants were asked ‘Do you know how to prevent Coronavirus from spreading?’, participants in almost all consultations (40 out of the 42) were able to name at least some of the official prevention messages on ways to reduce the spread of the virus and protect their families. However, noticeable difference between demographic groups were recorded.

All five FGDs conducted with the host community revealed a high knowledge and understanding of basic COVID-19 prevention measures both those on hygiene and social distancing, regardless of gender, age or ability.

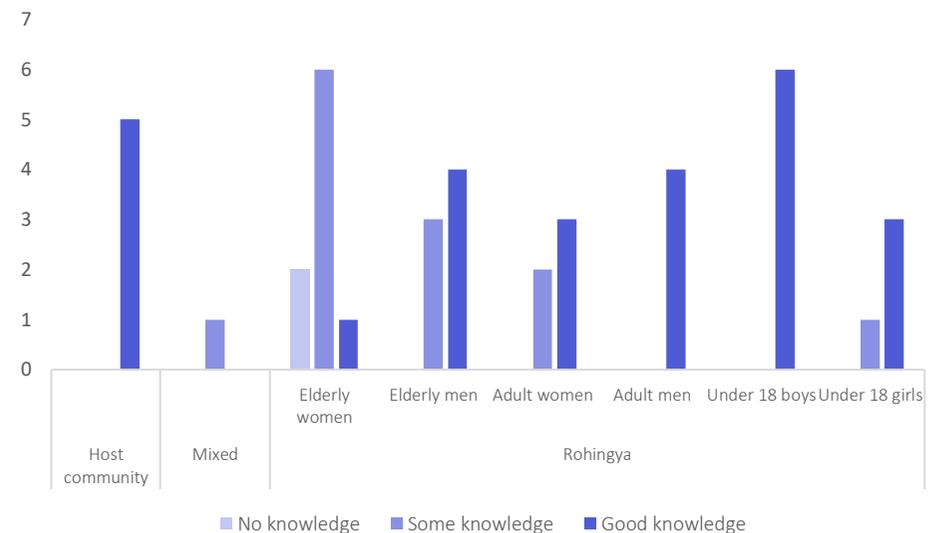
“We all have to maintain distance at least 3 feet from each other. Always keep neat and clean and clean hands with soap and water. I got a training on Coronavirus, how

it spreads, what the impact of this virus if it attacks in human body. We have to use tissue or napkins when we cough and sneeze or have to bent elbow when sneeze.”
(Host community, older females, FGD, Camp 24)

However, as illustrated in the figure 1, among Rohingya participants, knowledge of prevention measures varied significantly between demographic groups. 14 consultations (11 KII and 3 FGDs) were classified as having ‘some knowledge’ as they discussed some prevention measures.¹ For example, they mentioned hand washing and cleanliness, but not social distancing, or they were able to name some of key messages, but they were unclear why those measures would help protect them.

When examining the results by gender for Rohingya, the vast majority of male Rohingya participants (14 out of the 17 consultations) were able to discuss all key prevention measures, with older male participants in 2 FGDs and 1 KII classified as having only ‘some knowledge’.

Figure 2: Comparing overall knowledge of COVID-19 prevention measure across demographic groups



¹ In Table 1, each FGD and KII are represented as one data point per interview.

“We know that it is a transmitted between one another, we shouldn’t stay close to each other. If we need to go outside, at that time we should wear masks and we do not have to go to the place where people are gathering. And we need to conduct namaz [prayer] separately at home. In my understanding, I heard that people die from this disease. Because of that, we have to live clean, wash our hands with soap, wear masks and we should not go to the place where people are gathering” (Rohingya under 18 males, FGD, Camp 15)

“To prevent coronavirus from spreading, we should take quality foods. We need to use hot water, we have to wash our hands with hot water and keep our hands clean 24 hours so that there would not be any fuk (germs/insects) on our hands. The filth and garbage should be thrown away from our place in order to keep clean. The children should be kept clean by bathing them time to time accordingly.” (Rohingya older males, KII, Camp 15)

Knowledge of prevention measures among female Rohingya participants was more varied compared to male participants. Two of the five consultations with adult women and eight of the nine consultations with older females were classified as having only ‘some knowledge’ or ‘no knowledge’ (2 KIIs with older women) of prevention measures. Participants in the consultations conducted with under 18 females demonstrated a better understanding of prevention messages for COVID-19, with only 1 KII unable to adequately explain her knowledge of the main COVID-19 prevention measures. Those who displayed less comprehensive knowledge tended to focus on general cleanliness over other key prevention messages such as social distancing and were less likely to discuss how the virus spreads between individuals.

“We don’t know frankly but we heard from the NGO people that the people who are infected by coronavirus need to use mask and when they sneeze they can’t use the palm of the hand, they have to use the elbow. And we have to stay clean. And we have to wash the scarf if we use it for the sneeze. And when they sneeze, they need to use tissue then they need to throw away the tissue to the dustbin. We know that.” (Rohingya under 18 females, KII, Camp 16)

“We have to stay clean and we have to filter the water. And we have to wash our hands with soaps. And we have to wash our dishes. And we should drink purified water.” (Rohingya older female, KII, Camp 3)

In discussions with people with disabilities, participants in five of nine consultation displayed a good understanding of all key prevention measures, two of which were KII conducted with carer and PWD. Three consultations (1 KII and 2 FGD) displayed some knowledge and one older female identified as having no knowledge of any of the prevention messages.

“They are telling us to wash our hands and legs with soap and to keep our clothes clean. I am also hearing that it is a Kurabiyaram (chicken’s disease), it spreads from shelter to shelter. We should recite du’a and pray to Allah to save elderly people and small kids from disease.” (Rohingya older women with disability, KII, Camp 5)

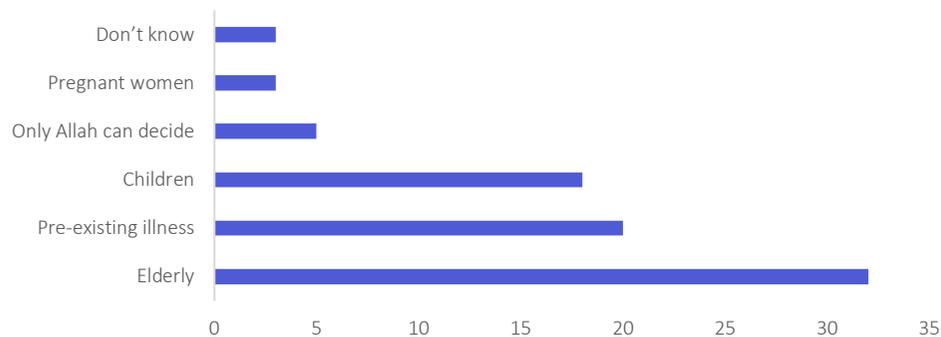
“I didn’t hear about this from anyone. I heard that people are dying in Dhaka. I don’t know exactly. I heard from my sons to ‘stay clean and fresh, and don’t stay filthy.’ Allah will protect us. Allah is the protector. You are reliable people. We have to pray to Allah ‘Oh Allah! Keep us in peace.’ We must worship Namaz and pray to Allah and recite prayers. If we don’t perform Allah’s work, Allah will give us the disease. If we do Allah’s work then Allah won’t give it to us.” (Rohingya older females with disability, KII, Camp 20ext.)

Vulnerability

When asked **‘Do you think some people are more or less likely to die from Coronavirus?’**, the vast majority of participants across the different consultations (32 out of 42) identified the older people as the most vulnerable to developing the most severe symptoms of the virus, with more than half of those also naming people with pre-existing illnesses. The explanation given was that these groups of people generally have poor levels of health and less ‘energy’ which participants explain would make it harder to overcome the virus if they were to contract it.

“Older persons who have been suffering from different types of diseases like diabetes and asthmas are more likely to have coronavirus. I think like that... because they have been struggling with these different types of troubles.” (Rohingya under 18 males, KII, Camp 16)

**Figure 3: Both host community and Rohingya:
Who is more likely to die of COVID-19?**



In addition, among the 32 consultations in which older people were identified as more vulnerable, 18 identified children as more vulnerable (8 males, 9 females and 1 mixed) because they believed them to be more likely to be 'dirty' and are thus more likely to contract the virus. Those that were unsure, or seemed to not have heard specific messages on who is more or less vulnerable to developing more severe symptoms of COVID-19 were still able to identify older people and those with pre-existing illness. This was largely because of their general perception of people with poorer health being more susceptible to illness. However, using that same logic some also named pregnant women and infants among those vulnerable to COVID-19, suggesting that they have a lower immune system or strength that is needed to fight the virus.

"Elderly people will be affected more because they are weak and have less strength. And the little babies also will be affected. The adult people will be affected less." (Rohingya older women, KII, Camp 3)

"The people who don't keep clean - it causes more harm to them. I mean, there are some people who don't keep their children clean or wash them five times a day and don't wash their hands before feeding them. There are also the persons who do mulakaat [shake hands] with each other and hug. I can see them. Elderly and children are at high risk. My guess is that children and elderly persons are at risk. Because some elderly persons have cough and asthma." (Rohingya adult woman with a disabled child, KII, Camp 18)

Participants in five consultations explained that only Allah can decide who is more susceptible to severe symptoms of COVID-19. These were spread across different

demographic groups: older Rohingya women (1 KII), host community religious leaders (1 FGD), older men (1 KII and 1 FGD), and a mixed interview of host and Rohingya with disabilities (1 FGD).

"My uncle is right, if Allah wants, no one can survive whether he is child, young or old. We have 116 million people among them only 50 people died and it's not a very huge number. So, we can't say that people have been died because of coronavirus but they died for many other reasons. It was decided by Allah who can live or die." (Host community religious leaders, FGD, Camp 24)

Health seeking behaviour

Key findings:

- Regardless of demographics, the vast majority stated that they would seek medical treatment if they believed that they had contracted the virus.
- Knowledge about how COVID-19 is treated and what hospitals and treatment facilities do to aid recovery is low across all demographics and is a source of confusion and anxiety among the majority of participants. Even among people who understand that many people can and have recovered, they believe that there is no cure.
- Only a very small minority expressed belief in false treatments despite many other participants report hearing these rumours. They were largely dismissed as false information.

The hypothetical question "what would you do if you thought you had contracted COVID-19?" was asked in each consultation. Participants in 35 of 42 consultations stated that they would seek medical treatment at the nearest health facility, though it is unclear whether this represents actual intended behaviour or whether respondents understood that this was the "correct" answer to be given.

Of the remaining participants that said they would not visit health facilities, four were older Rohingya women, two of which were disabled. While all reported that they wanted to go to the clinic, they saw themselves as unable to reach it and reported recent negative experiences at health facilities. They also believed that health services would be unable to provide high quality care or treatment.

*Facilitator: "What would you do if you thought you were sick?"
Participant: "I will tell my suffering to my grandchildren and ask them take me to the"*

clinic. Without them I have no one to share this with. I am feeling so worried, what could we do and where can we get medicine if this disease affects us here. I have no one to bring medicine for me as my sons are living separately with their individual family.” (Older Rohingya females, disabled, head of household, KII, Camp 5)

Participants said that they would mostly inform a doctor if they felt ill, but many also responded that they would tell their family members, Mahji, or familiar humanitarian agency. Again, whether these reports constitute their actual intended behaviours is unclear given the high level of reported mistrust and fear of medical facilities. Out of the 36 consultations conducted with Rohingya, 16 (across all demographics) expressed concerns with the current reliability and capacity of the health care clinics to meet their needs and to treat the virus – due to how people are generally treated at clinics.

“People will go [to medical clinics] if they are safe but people will not go if it’s like the clinics here because everyone is seeing the system of the clinics in the camp and what they are doing. If they provide proper treatment, then people will go.” (Rohingya under 18 males, KII, Camp 16)

Despite the majority of participants expressing that they would seek medical treatment if experiencing COVID-19 symptoms, a small number of participants expressed concern that they do not know enough to be able to distinguish the symptoms of COVID-19 from other common illness such as the flu and common cold. They were similarly concerned about how to know if there is already a case of COVID-19 in the camps, which would impact their ability to seek timely medical treatment.

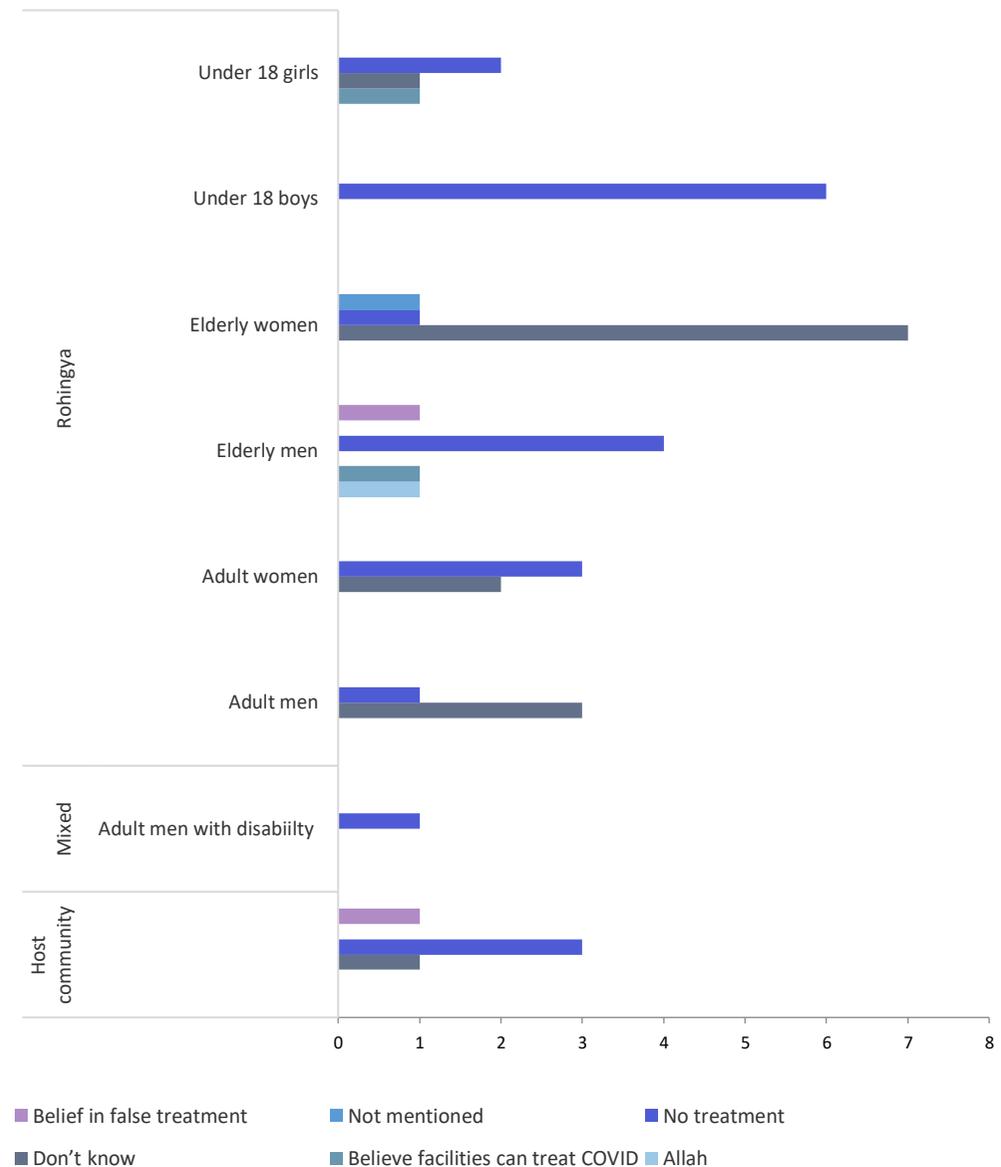
“We heard some of symptoms of coronavirus are cough and fever and so on. Always, we suffer from coughing, diarrhea and other sickness five times per month. So, how can we know that we have coronavirus? Normally, my children suffer from coughing two times per week. After giving them medicine, they recover. We hear that the symptoms of coronavirus are like that. So, we don't understand about it.” (Rohingya Adult male, FGD, Camp 16)

Knowledge of treatment measures for COVID-19

All participants were asked whether they knew of treatment for COVID-19. Participants in half of all consultations (21 out of 42) stated that there is no treatment for COVID-19, and 14 stated that they had not heard whether or not there is a treatment.

Only a small minority of consultations (two KIIs and two FGDs) from varying demographic groups reported that they believed in rumoured treatments. Within this, 1 KII with a husband and wife with chronic illness believed that drinking hot water would kill the virus so there

Figure 4: Do you know what treatment/s there are for COVID-19?



would no need to go the hospital. A group of under 18 girls from the host community and a group of older Rohingya males, both named cures they believe had been created overseas, including a treatment created in Japan and the use of Chloroquine in America to treat virus. In addition, an older Rohingya man expressed that faith in Allah alone would cure the disease.

“According to the information which came from America, Americans thought that the treatment which kill the fuk of Malaria will prevent people from getting coronavirus if people take it. I have forgotten the name of the treatment. In fact, the Americans advised people to use the treatment to prevent coronavirus the way people use it to prevent malaria.” (Older Rohingya males, FGD, Camp 15)

“Yes we heard the patient of corona let them go to an isolation of hospital. Some patients are recovering with treatment and some are dying. I have heard that one tablet has been discovered in Japan to cure the virus.” (Host community, under 18 female, FGD, Camp 24)

There were a large number of participants, from 14 consultations, mainly older Rohingya women and adult Rohingya men, who were unaware if there is a treatment for COVID-19 and what would be administered should they become infected.

“How can I know that? The doctors shout know about it. They are telling us to go to doctor if someone is feeling sick.” (Older Rohingya females, KII, Camp 20ext.)

“We don't know about the treatment of coronavirus. We know that we have to drink boiled water more and more and not to eat frozen food which will make us have a runny nose. That's all. We should avoid being cold. When we leave from shelter for any emergency at midnight - at that time we should wear warm clothes.” (Adult Rohingya males, FGD, Camp 16)

The lack of knowledge on how COVID-19 is treated seems to be a source of confusion and anxiety among the majority of participants. Even among people who understand that many people have recovered and that there is not a cure, there was confusion and misunderstanding about what hospitals and treatment facilities would do to aid recovery. The perception that treatment facilities will be unable to offer much help will undoubtedly impact people’s willingness to seek treatment.

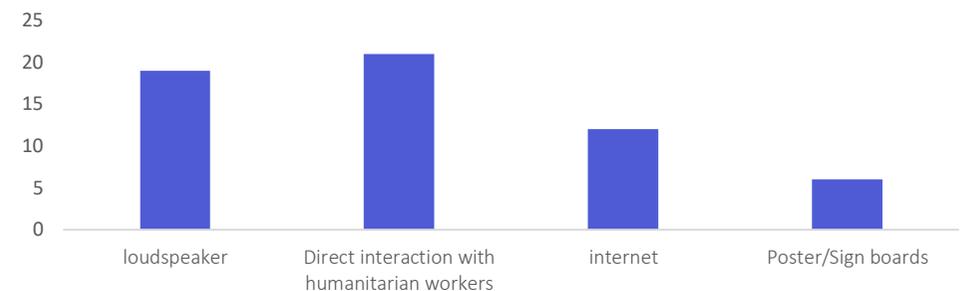
Information access

Participants in 40 of 42 consultations were able to name at least one outside source of information on COVID-19. For the Rohingya, these sources are primarily humanitarians and others that work in and around the camps (e.g. CiC, police and host community), as well as

information available on the internet through personal messaging, social media and various international and Rohingya news sources. Among the host community, the primary information sources included government, TV, radio and internet.

The main methods of information delivery for Rohingya included direct interaction with humanitarian staff or volunteers in the camps (22 out of 36) and messages played over loudspeaker/microphone (19 out of 36) with a small minority also naming written forms such as posters. Participants in 12 Rohingya consultations across all demographic groups named the internet as a key information source, which is sometimes accessible on their mobile phones, depending on network coverage.

Figure 5: Main method of receiving information for Rohingya



Of the 9 consultations conducted with people with disabilities or their carers, only four have received COVID-19 awareness information in person from humanitarian agencies since the beginning of the COVID-19 response. In one case, this in-person information came from the carer. The two consultations in which participants stated not having received any information on COVID-19 from people outside their family, were conducted with older, disabled Rohingya women.

The sources of information that are being accessed by people with disabilities are similar to other demographics groups, as well as the challenges faced. However, the data does not lend itself to understand the extent of those challenges faced as a result of this. For example, many note that mobility restrictions make it difficult to go and seek out information, but this challenge is a lot greater for people with disabilities. It is well known that people with disabilities living in the camps struggle to access essential services and information even before the COVID-19 response. This is not only due to hazardous hilly and flood prone terrain which make movement extremely difficult for those with mobility challenges, but also because of the lack of adapted facilities. In addition, social stigma is a major social barrier that is preventing PWD access to services and participating in community activities

and important decision-making processes. (MSNA 10/2019, ADH, CDD, ASB 2017, Humanity & Inclusion 01/2019).

“Yes, we didn't receive enough information and also we are not able to travel from one place to another place due suffering from illness. So, we couldn't get information from the outside.” (Rohingya older man with disability, KII, Camp 16)

Overall, the vast majority of participants in consultations conducted with Rohingya (33 out of 36) stated that they are currently not receiving enough information on COVID-19. Participants across 16 consultations explained that this is due to poor network access in the camps. All consultations with under 18-year-old children revealed that the reduced presence of humanitarian agencies has led to a decrease in the awareness sessions where they received most of their information about COVID-19. Among those that displayed less overall knowledge of COVID-19 (mainly older Rohingya women), many seemed to be relying more heavily on second-hand information and a reduced diversity of sources.

“Before, we had internet connection, we got information through internet and from the NGO's volunteer who used to come to give update. Now, we are just getting a few information from the people.” (Rohingya under 18 females, FGD, Camp 1E)

Both host community and Rohingya participants expressed challenges in comprehending messages delivered through loudspeaker, despite citing this as a primary information source. Many explained that they either cannot hear the message clearly, are only hearing some of the message, and/or are unable to interact with the information that is being provided, which impacts their overall engagement and understanding. An older Rohingya woman explained that the loudspeaker that runs along the road is too far away for her to hear clearly. This was echoed in discussions with volunteers who reported that information and understanding is greater among Rohingya living along roads and relatively poor among those farther away from roads. Women reported being less likely to hear such messages because they were not allowed to go to the road or public spaces due to the practice of *pardah*.

Facilitator: “Did you receive enough information?”

Participant: “Not getting enough information.”

Facilitator: “Why?”

Participant: “Because more children and people are being loud around me. For that reason, I cannot hear [the loudspeaker announcement] properly. If I were a boy, then

I could go to the road and hear properly. We are women and staying at home all the time.” Older Rohingya females, KII, Camp 1E)

“Before [humanitarian agencies] always used to give awareness about hygiene home by home, now they are not coming here, just some people are alerting us with speakers. Even though is a good way of alerting everyone, but many do not understand clearly what they are telling. Instead of alerting us by speaker, it is better for us if they (NGO volunteers) raise awareness home to home because every women can understand their information.” (Rohingya Female head of household, KII, Camp 3)

Host communities seem to have more diverse and readily available access to information through a range of mediums, such as TV, loudspeaker, radio, internet, government messages through automated mobile voice messaging.² This has increased the access to information compared to Rohingya and is likely contributing to their increased knowledge of COVID-19, including prevention measures. There does not seem to be much difference in information sources or access within the host community between genders, age groups or levels of ability, but data samples of the host community were smaller, and further research is needed to clarify if this finding is generalizable. Regardless, participants in all consultations noted that they would like access to more information on topics such as the number of cases, support on how to dismiss rumours, additional information on how to prevent transmission of the virus, and treatment options. It was also mentioned in two of five FGD with host communities that they would like “awareness session from NGOs”, as some participants felt that refugees would know more about the virus due to their support from humanitarian agencies.

Participant 1: Facebook, YouTube, Friends' Facebook messenger, Television.

Participant 2: Besides we get information through using mike by govt and other agencies. They provided also leaflet.

Participant 3: Before closing school our teachers' shared information. NGO's always focus on Rohingya not host. They don't conduct usually awareness beside host community house's ground/yard. If they conduct and inform us majhi we know more information.” (Host community under 18 males, FGD, Camp 25)

“We got this information through meeting like today's consultation. Peoples are gossiping in the camp and also there is a loudspeaker on road. People watching TV. We got leaflet regarding coronavirus messages from humanitarian agencies” (Host community older females, FGD, Camp 24)

² Automated message that plays every time a call is made on a Bangladeshi network

Isolation

All people consulted were asked whether they were willing to isolate. Regardless of gender, age and ability, the vast majority of consultations (32 out of 42) reported their willingness to isolate, which was explained and understood as staying in a separate facility for treatment if they were sick to prevent further transmitting the disease. Most people seemed to understand how the virus is spread and the need to maintain physical distancing to protect family and community members. People reported being more willing to comply with isolation measures because of a lack of access to medicine and proper treatment within the camps, the need to protect family and the community, and their willingness to comply with the Government's rules. This attitude seems to have changed since earlier consultations, perhaps due to greater awareness of the epidemic, which is understood to be growing within parts of Bangladesh.

“Facilitator: Would you be willing to isolate yourself to protect yourself and others from disease?”

Participant: Of course, we will go into isolation to protect ourselves and other community people from spreading.” (Rohingya female, under 18, FGD, Camp 1E)

Though the majority expressed their support of isolation, many had reservations. Men, in particular, mentioned concerns and rumours about isolation and treatment centres (i.e. doctors killing the infected to prevent transmission) and reported this as the main reason they were afraid to go to isolation centres. In two consultations, females under 18 years stated their willingness to isolate, but reported that they were afraid they wouldn't be able to see their relatives or keep communications with loved ones.

Participants in eight consultations, which consisted predominately of older and adult Rohingya men and women, reported being opposed to or dubious about isolation. The main reasons identified included:

- Uncertainty about the quality of treatment and isolation centres (2)
- Willingness to isolate if symptoms arise but express not wanting to quarantine as a preventative measure (2)
- Belief that Allah will save good Muslims from the virus (2)
- Unwillingness to isolate alone without relatives (2)
- Preference for self-isolation within their shelter by moving beds and putting sick people in different rooms (2).

In one consultation with a PwD, it was stated that it would be impossible to go into isolation due to their inability to move and the lack of mental strength to face isolation alone.

“We will not send this disabled person there. We will not send him and he will also not go there. You cannot move him from this to that house also [referring to a house beside his house]. My brother is not physically and mentally strong. He always scared of going here to there.” (Rohingya male with disability, FGD, Camp 18)

Isolation with other genders and other communities

A follow-up question regarding isolation prompted participants to think about whether they would be willing to go into isolation with people of different genders, outside of their immediate family members, or with other communities.

As the consultations were conducted in such a way to promote open discussion, not all consultations produced an answer to this secondary question. **In the 30 consultations that did, the vast majority (23), regardless of population group, gender and age, made it clear that spaces need to be separate for men and women to be able to follow Islamic rules.** People stressed that in the centres there needs to be the possibility to have partitions or stay in separate rooms for a range of reasons, including GBV.

Facilitator: “Would you isolate with people of another gender?”

KII: “No, how the males and females can be isolated together? We have the partitions in our shelters even. Thus, how could we stay there without partitions between males and females?” (Older Rohingya female, KII, Camp 5)

“No, people will not go because women feel shame to be with men. If they have to stay with men, there may be violence.” (Rohingya female, under 18, KII, Camp 16)

Although both males and females consulted stressed that it would be better to have gender segregated spaces, it was highlighted by some (five consultations) that in emergency circumstances they would be willing to be in a mixed gender isolation space.

Facilitator: “Would you go to isolation if the male and female have to stay together?”

KII: “There is no difference male or female in the condition of illness, we all have to stay there.” (Rohingya male, KII, Camp 5)

When asked whether people would be open to staying in isolation facilities with different ‘communities’ or population groups, it became clear that the concept of ‘community’ varied among participants.

Among Rohingya participants in the 23 consultations which recorded a response to this question, most interpreted community as ‘people with the same religion’. As a result, participants across 15 of the 23 consultations (10 of which were conducted with females of various age groups) reported an unwillingness to isolate with other communities. Over half

of those explicitly referred to religious communities such as Hindus and Buddhists when expressing their hesitancy to isolate with “other communities.” In three consultations participants stressed the need to isolate with Rohingya only.

Facilitator: “Would you isolate with people from other gender? Another community?”

Participant 1: “No. We Muslims should be separated in the isolation.”

Participant 2: “Yes, we should live together with not only Muslims but also other community in the isolation. But we should live separately with male and female there.”

Participant 1: “I mean that Muslims, Hindu and Buddhist should be kept separately there because in the Buddhist religion, when anybody dies, he/she will be cremated after his/her death. In our religion, the body can’t be burned according to our religion. If they die together in the isolation, at that time they will be burned together with other communities. Cremation after death is prohibited in our Islamic religion. So, I’m telling that we have to live separately them.” (Rohingya Male Under 18, FGD, Camp 15)

From consultations with the host community, the understanding of “community” distinguished between Bangladeshi and Rohingya. Among five consultations with host community three reported that Rohingya and host community can be isolated together as both are Muslim but other religious groups should be separated.

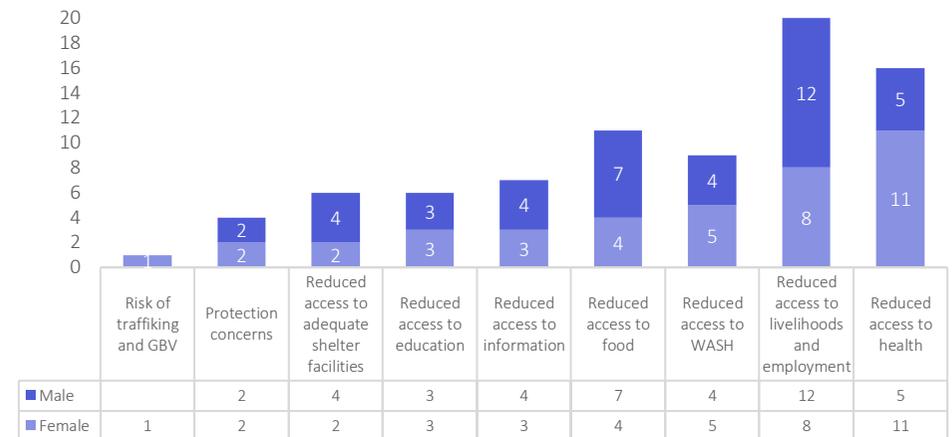
“Rohingya and host will stay together as both are Muslim but other religious people should be separated.” (Host community religious leaders, FGD, Camp 24)

Major concerns & challenges

During consultations, respondents were asked to talk about their greatest challenges based on their demographic background and current situation with COVID-19, as opposed to speaking more generally about the challenges their community faces. This allowed facilitators to better understand how different groups were affected by the COVID-19 pandemic. Throughout the discussions the vast majority of respondents believed the risk of COVID-19 was the most pressing concern across all population groups regardless of gender or age. However, different protection concerns and the secondary impacts of the COVID-19

response were noted by different participants.

Figure 6: Concerns and challenges



Access to livelihoods and employment

Participants in 20 of 42 consultations mentioned **access to livelihood and employment opportunities** and reduced support from the humanitarian community (12) as one of the main concerns impacting daily life. Access to income was the most commonly reported concern of those consulted, regardless of gender or age. This was due to the fact that regular income generation activities have been disrupted by movement restrictions, market closures, and reduction in humanitarian-led income generating activities, including Rohingya volunteers within NGOs and cash for work programs. A lack of income was also reported to limit Rohingya’s ability to seek treatment at clinics and buy essential goods (i.e. food, clothes, hygiene items).

“Local NGO worker and day labor are jobless now. Madrassa teacher have limited income and all madrassa-moktob are closed. They are not used to asked for help from others because it is related to their self-respect [izzot]. For this reason, Imam are very much affected right now” (Religious leaders from host community, FGD, Camp 24)

“Now my brother cannot go for work because the cash for work activities are stopped by the NGOs. So if he cannot earn money, then how he will buy necessary things and how will we eat. Now this is a crucial concern for my family.” (Male under 18, KII, Camp 18)

“The largest problem is that I am not being able to travel other places. There is no money at my home, and I can't even go anywhere. I can't eat what I want. I can't take what I want. That is why it's my largest problem. When the markets were opened, I could live by begging there. Now, I can't go anywhere” (Rohingya male with disability, KII, Camp 1E)

The host community also reported concerns over the lack of movement and inability to earn an income. There is the perception that Rohingya are receiving more support from the humanitarian community. In a consultation with older women from the host community they reported the need to request support from Rohingya.

“Participant 1: All benefits are for only Rohingya. Our husband can't go to work outside. We are starving every now and again.”

Participant 2: Most of the time we borrow and beg soap and food from Rohingya.

Participant 1: Many of us did food card as they are poor. But it has been three months WFP stopped it.

Participant 2: We don't have sufficient soap and water so how can we keep clean ourselves even we live in overpopulated area. Despite our desire, we can't maintain distance. We are troubled for food also. Host community are deprived from all facilities. Bangladesh Government doesn't help us and NGO don't also.” (Elderly females, Host Community, FGD, camp 24)

In one FGD conducted with a group of host community and Rohingya men with disabilities, they cite that men's inability to work given the current situation was a source of tension between husbands and wives.

“As men who are disabled, the problem is that we are having family disputes because we can't bring foods and other things in this situation. So fights are increasing between wives and husbands. Nowadays we can't work anywhere so this is also a problem.” (Mixed host community and Rohingya males with disabilities, FGD, Camp 24)

Regardless of gender and age, access to food has also been mentioned as a major concern and a consequence of reduced humanitarian activity, lack of income and market closures (11 consultations, including 2 FDGs with host community). It was also reported that latest distributions providing people with rice, lentils and oil are not believed to provide adequate nutrition (3 consultations).

“In camp, we are facing difficulties with daily expenditure and to take food as well because we are only getting rations from distribution. There is no one in my family who can earn money. So I can't buy quality because I lack money. And also

distribution process is being changed now. We receive ration once per month. If there is two members in a family, they received 28 of Kg rice but now they receive 26 Kg of rice for two member family.” (Older Rohingya men with disabilities, KII, Camp 16)

“The government creates by not allowing more people to come here so we are not getting more food and more service. We are facing lots of troubles for food actually.” (Rohingya male with disabilities, FGD, Camp 18)

Access to health

Access to health, combined with difficulties in procuring medicines, seemed to be the second most pressing need. This was particularly reported among women. Among Rohingya, in the 16 of 36 consultations in which this was reported as a concern, 11 were with women. Health concerns were reported to be most salient for older women and women living with disabilities. Access to clinics is becoming more challenging for them due to the recent movement restrictions and a lack of income, as well as the reduction in services offered by hospitals and clinics since the COVID-19 response began. Some women reported being turned away by doctors because of the fear that they were infected by the virus and others reported long wait times or rejection at facility due to patient limits as barriers to receiving treatment.

A possible reason for these two demographic groups' focus on health care access is that they are reliant on these services more than others due to pre-existing health conditions. In one consultation with a female head of household, it was reported that because hospitals are closed, pregnant women can no longer go to hospitals for delivery.

Participant: “I am suffering with eyes. Though I have taken many treatments. I can able to see dimly. These treatments are not making me feel better.”

Facilitator: “Didn't you go to health centre?”

Participant: “I went there two times and came back.”

Facilitator: “Why?”

Participant: “They don't allow us to go in. We need to sit whole day on waiting bench. My daughter-in-law also came back after going there some days before. We went early morning and it had been evening but they didn't allow us. How long could we stay there by sitting that's why my son took me back by carrying me. And they also tell me to ‘come tomorrow’ or ‘come on the day after tomorrow.’” (Older Rohingya female with disability, KII, Camp 20ext.)

Facilitator: “How have the changes in services from the Coronavirus affected women and girls in the camp?”

Participant: "As health centers were closed, we didn't get any medicine. Now we couldn't go anywhere for medicine when we are feeling sick. Some hospital are still open but it is so far from our block, if I will go there, we should stand in line a long time for them to provide us a few medicines. The doctor are avoiding us because they are thinking that we had Coronavirus virus and it will transmit to them." (Adult, Rohingya Female, KII, C1W)

"If I get sick, I will not be able to take treatment because my father and brother is jobless. Before, they had work so that I was able to get treatment. But now I don't have money to take treatment here. We have hospital but if we go there with fever or other disease, they just provide us paracetamol. If anyone goes there, they keep the patient out of gate and call one by one but the patient cannot share the important thing to doctor because they meet us quickly and the patient doesn't get proper treatment. (Rohingya female, under 18, KII, Camp 16)

Access to WASH

Access to water, hygiene facilities and hygiene items is also reported as a major concern. In total, five of 19 consultations with women (including two FGDs with women from the host community) reported access to WASH as a challenge. In particular, this seems to affect young girls, who reported struggling to access menstrual hygiene items. In order to avoid crowds and being harassed by men at the latrines, women and girls used to access the toilet at strategic times during the day, such as while men were working outside the shelter. However, due to the current movement restrictions and loss of work, their access to these facilities has been reduced. Besides being a health and protection concern, this is reported to be a source of anxiety for some.

"Women and girls can't go to toilet and outside. Before, all the people went to each works. The shelters are likely close one with others here. There are 100 shelters in one block and only one or two toilets in one block. When all the people (men and boys) go to work then we used to use the toilet. But now, we can't go to toilet in the daytime as all the people [men] are at each home. We see lots of other people when we go to toilet in the daytime because all the people are staying surrounding in one place." (Rohingya Female, under 18, KII, Camp 16)

Women from the host community reported access to WASH facilities as a concern as well, and were especially concerned about needing to share a toilet with Rohingya, reporting cleanliness and overcrowded facilities as an issue. Challenges in maintaining hygiene during menstruation because of an inability to afford necessary items was also discussed at length in a FGD with older host community women. Some mentioned that they borrow items from

Rohingya women to cope.

"We don't have individual latrine. We all use same latrine and bathroom with Rohingya. We use one latrine maximum 15 persons and use one soap together. So the virus will spread more. So, it seems difficult to maintain hygiene and stay apart as we live in overpopulated area." (Host community, under 18 girls, FGD, Camp 24)

Participant 2: "During our periods we can't maintain hygiene, Rohingya are receiving sanitary napkin, soap, dettol."

Participant 1: "We are deprived from everything. They all don't know how to use it. Sometimes we borrow from them [Rohingya]. We don't have capacity to buy so we have to use small cotton napkin." (Host community, older females, FGD, Camp 24)

Reduced presence of humanitarian actors seems to have had the greatest impact on WASH services and facilities, camp cleanliness and access to information. The lack of cleanliness and upkeep of essential hygiene facilities and public areas in the camps were identified as sources of stress for both Rohingya and host community participants across demographic groups as they believe that dirtiness will increase the risk of contracting the virus.

"Now in camp fewer NGOs are working than before. There used to be 10 WASH volunteers in each block but now there are 5 volunteers. That's why the block became dirty." (Rohingya Older male, KII, Camp, 1E)

"NGO worked in full swing before so the camp area was clean but now they reduced their activity. That's why the camp is getting dirty again. Most of drainage blocked by water, garbage has not been cleaned for long time. That is why there is a bad smell increasing day by day. Most of the drainage is near to our house - so this dirty environment will increase more disease." (Host community, older male, Camp 24)

Access to education

The vast majority of participants aged under 18 years, both female and male, Rohingya as well as host community, highlighted access to education as a major concern. This is perhaps most obvious due to the school closures which began several weeks prior, with the implementation of a nation-wide lockdown and essential service restrictions. However, it is important to consider that this is not only having an impact on children but also on parents and families who are now spending all their time together in cramped conditions during the hottest season of the year.

There are lots of difficulties for us. Now, we are staying in the camp and we can't study. I am under 18 years. This young life is for study but we can't and the time is passing but we can't study. In here, we cannot go out properly because if we go

bathroom or toilet or tube well, boy's see us and our shelter is small. In one place, we have to stay 10 people together but this place is suited for one person. We are just wasting our lives. (Rohingya female, under 18, KII, Camp 16)

Participant 1: "Our largest problem is that we can't learn education and do anything like how we used to do (in Myanmar)."

Participant 2: "We can't get education and freedom to visit anywhere in the camp as if we did in Myanmar. The youths who have no any job, they get married early in the camp." (Rohingya male, under 18, FGD, Camp 15)

Participant 1: "As a boy I faced problems like I can no longer play outside, school is closed, there are restrictions of movement."

Participant 2: "My largest problem is school is closed. Another problem is playing games. We all agree that the largest problem is the school is closed." (Host community males, under 18, FGD, Camp 25)

Protection concerns

Host community respondents reported concern over an increase in criminal activities because of reductions in income for both communities. Rohingya were more likely to report an increase in tensions with the host community, especially among young men, and a growing number of security issues in the camps.

"I am very worried about the increase in the criminal activities, because if people have no income source they will think of alternate ways to earn money and they might engage with criminal activities. For example, in our area, we have seen some incident happened like hijackings. So, there might be a chance that this sort of incident will increase. All of us are worried about this issue. We are still worried about going outside at night because of the hijacking incident. (Host community, Religious leader, FGD, Camp 24)

Participant 1: "Due to coronavirus, government prohibited us from going outside of the camp. In a long time ago, we could not go to the Kutupalong camp. When we come from anywhere at night time the local community use to rob us and they snatch what we have."

Participant 2: "As they said, I saw by my own eyes many times that the local community used to rob the Rohingya people." (Rohingya male PWD, FGD, Camp 18)

Participant 1: "When we can't go outside of the camp in current situation, the host Community are doing robbery, torturing, beating and catching us. So, we are feeling so worried about it. We will be feeling good when the NGOs will take the action on

the host community. When the host community see any good (valuable) things in the Rohingya's hand, at that time, they steal it. If we try to response to them, more problems are happening, so we have to give up. Some days ago, a problem happened between host community and Rohingya community at night."

Participant 2: "The host community beat the boys after coming to the shop without any reason. We don't try to fight or argue against them because we are afraid of them because they have guns." (Rohingya male, under 18, KII, Camp 16)

During a key informant interview with 2 Rohingya girls, they stress the risk of trafficking and GBV by the host community – possibly in light of the recent cases of trafficking affecting Rohingya that have been publicized in news media.

"We are worried most about trafficking and Rape. Because the host community are trafficking people more and if they find us alone, they will rape us. And there is more rape happening here but we don't know more about it because we don't go out much. Those who are working with NGO may know everything. (Rohingya female, under 18, KII, Redacted Camp)

Access to adequate shelter facilities

The lack of appropriate shelters and adequate space was mentioned by both women and men during seven consultations with Rohingya. The lack of space, combined with the hot weather and movement restrictions was raised as a main challenge during three discussions with men.

"Nowadays it's very hot and staying under plastic shelter is very difficult at daytime so we will need to go out from house and have fresh air by going near road or somewhere". (Older Rohingya male, FGD, Camp 24)

"It is summer season now, we are finding it hard to stay inside the shelter due to the heat because we don't have a fan to get air. We have no solar panel. So, it is difficult for us to pray namaz under darkness inside the shelter and to take care of children at night. The children are being bitten by mosquito and we don't have mosquito nets. We are living in a over crowded area and mosquito are multiplying from the garbage. (Rohingya older male, KII, Camp 15)

"Our movement is also limited in camp. So, we can't move anywhere. We can't move anywhere. We don't want to stay at home the whole day as the shelter is quite narrow. In fact, movement restriction are our problem." (Rohingya under 18 males, KII, Camp 16)

The lack of space and privacy is also impacting the life of women and girls and their ability

to conduct a normal life in the context of camp.

“We need more security for women because security is very important for life and we need good treatment in the clinics. And it is very important for the females to get peace. Men can go anywhere and do whatever they want but we can’t go out. And if we see man, we feel very shameful in our culture. Our shelter is very small and if we have to stay eight people in a small shelter which is 10 yards’ length and 8 widths, it is not possible. Not only for us but also everyones shelter is the same. And my son has gotten married, and now it’s too difficult to stay here inside our house because it’s small. We have a different card [SMART card] but one shelter.” (Rohingya under 18 female, KII, Camp 16)

Participants in eight consultations with Rohingya, mainly adult and older women, explicitly identified a lack of mosquito nets as one of their most pressing needs due to the seasonal increase in mosquitos combined with their inability to leave the shelter for a more open space within their camp. In addition, participants explained that it is difficult to practice social distancing within the household when the whole family is sleeping under one mosquito net.

“We don’t have mosquito net, from the evening mosquitoes bite a lot, mosquito net was given to us long ago. We are in trouble now because of mosquito. Ramadan month begins in a few days and we are having trouble thinking about Ramadan fasting. I think from mosquito bites or heat the disease can spread.” (Older Rohingya female, FGD, Camp 23)

Access to information

As highlighted earlier, access to information was also mentioned as a key concern for the majority of participants regardless of age, gender, ethnicity or ability. Everyone expressed a desire for more information and for support for people who face greater mobility issues. Those with mobility restrictions faced the greatest barriers in accessing information, including the elderly and those with disabilities. Rohingya participants identified different information needs that were outstanding. The major themes that were identified are:

- Information about the virus itself as opposed to prevention messaging.
- Information on movement restrictions and how long they will last.
- Given the conditions in the camps many requested information on additional measures they can use to protect their family as social distancing and other prevention measures are difficult to implement.
- About what information was a rumour or untrue.
- How people can be informed if there are cases of the virus in the camps and the testing process.

- The type of treatment for people with COVID-19.
- More information on the humanitarian programs that are still being conducted.
- Whether more Rohingya volunteers can be used to support the response as humanitarian staff are unable to access the camps.

“People fear when they get cough, runny nose and fever. So, we want to know how we can be checked that coronavirus happen or not here!” (Rohingya under 18 males, KII, Camp 16)

For host community, the major information gaps that they expressed are similar to Rohingya with the major questions centered around:

- More detailed information on the virus and how to tell rumours from factual information.
- The kinds of support will be provided for those who have lost their jobs and are going without food.
- The sorts of medical treatment that will be used to treat the virus.
- Duration of lockdown
- What services are being provided to the host community versus the Rohingya.

“When movement restrictions will be open? And what is the solution for poor people who need food to survive in the future” (Host community older males, FGD, Camp 24)

Ways Forward

While it is often known and noted that disasters of all kinds disproportionately affect various groups differently, this does not excuse or eliminate the need to explore these impacts in order to better mitigate them and provide tailored assistance. Hopefully this edition has been able to highlight how the COVID-19 epidemic is already impacting different groups within the response so that more tailored forms of assistance and information can begin to be provided to these groups. These findings no doubt need to be explored further, especially with the particular groups who demonstrated concerningly lower levels of awareness and suffering greater impacts from the lockdown, the economic impact of the response, and the increase in protection related concerns. While this may be difficult as the epidemic spreads and cases might arrive in the camps, it is important that programmers prepare and put in place alternatives for the foreseeable future before these consequences protract and grow. There is still time to “fill the gaps” in information provision and build a more robust understanding of the virus, the global epidemic, and how the response is likely to proceed in order to further build trust.