

The Stories being told: Rohingya report on the epidemic

Edition 7, 13th July 2020

The prevalence and impact of COVID-19 in the camps today remains unclear and different sources of information paint different and conflicting pictures of the situation. Official numbers of positive COVID-19 cases and deaths confirmed through testing suggest the virus is yet to spread across the camps and that its peak lies ahead. This is reinforced by the fact that medical facilities have not experienced a surge in people seeking treatment, nor a surge in the use of quarantine facilities. There has also been a low number of reported deaths. However, research conducted by CwC Rohingya researchers between 25 May and 25 June 2020 suggest widespread illness moving quickly through communities and an increase in deaths during that time. These reports were corroborated by other sources within the response and discussed in sector meetings. Symptoms reported included fever, coughing, and severe aches and pains, as well as deaths, primarily among older people. Whether these symptoms were COVID-19 or a flu is unclear and has yet to be determined.

The volume of these reports combined with reluctance among the Rohingya to visit health facilities during this time merit their further consideration. Engaging with these reports in a genuine and sensitive manner is important for building trust and can reveal new ways to learn about how people share information. Although recently there has been a slight increase in Rohingya consenting to testing and reporting symptoms, this does not address the reason behind the delay in support from the camps. Exploring why the Rohingya were initially reluctant to engage with the response will help understand how to better improve response messaging and planning moving forward.¹

This edition of COVID-19 Explained explores these reports to better understand how the Rohingya understand their experiences. It is both an exploration of what it could mean if the reports are true and what it means that the reports are *believed* to be true. The emphasis is on experiential understanding – people's lived experiences – rather than scientifically verifiable data through a method such as testing. The testimonies are from researchers, their relatives, community leaders, and key contacts in the camps. Whether or not the illness is COVID-19, the exercise unveiled issues within the current response that discourage the Rohingya from seeking testing and treatment for COVID-19 symptoms and explains these fears.



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¹ According to the Health Sector led by WHO in Cox's Bazar, the number of individuals consenting to testing in the camps has jumped from an estimated average of 8 per day in June to a minimum of 25 and a maximum of 57 tests per day from the 1st to the 12th of July. <https://www.humanitarianresponse.info/en/operations/bangladesh/health>
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Key Findings

- **Rohingya researchers are now clearly reporting and providing evidence that an earlier rash of flu that occurred in many parts of the camp in late May to early June is believed by them to be the result of widespread COVID-19 infection in the camps.** Their reports are corroborated with details and evidence that suggest there was an increase in deaths, widespread illness matching COVID-19 symptoms, and concerted effort to hide these events from authorities and humanitarians. Many people now believe that they are no longer at risk of COVID-19 as a result.
- **For the Rohingya, reporting symptoms became synonymous with community risk; they viewed it as informing authorities of something that could negatively impact the community's protection and safety.** Social pressure within Rohingya communities, reinforced through mechanisms such as shame and stigma, discouraged people from reporting symptoms or disclosing COVID-19 related deaths. Traditional leaders who encouraged testing and reporting were denounced by the community.
- **The Rohingya's understanding of the benefits of treatment differed from that of the humanitarian response. A general consensus seemed to have formed in the community not to test and to avoid seeking treatment.** This weighing of options was discussed with the researchers, and while Rohingya's reasons for not-testing are many, their understanding of the potential benefits of testing and official treatment in response facilities are limited. The response's reasons for testing, quarantine and isolation were not agreed on, accepted, or understood by the Rohingya. Solely attributing this to a lack of understanding of the public health guidance ignores the reality that the Rohingya understood that they were asked to report symptoms, test, and go into isolation, but their own cost-benefit analysis led them to believe it was detrimental to them and thus they chose to ignore it.
- **The Rohingya overwhelmingly decided not to seek treatment, not to test, and chose to manage COVID-19 themselves.** The response failed to fully understand past Rohingya experiences around medical facilities, despite these being alluded to. Their historical experience and how this shapes behaviour were not taken into full consideration when planning health responses, particularly the COVID-19 response.
- **Where isolation facilities were perceived to provide good quality care, there was more willingness among the Rohingya to attend those facilities.** One such facility was said to provide "good quality" care by Rohingya who described in detail the practices of the facility. This shows scope for change in attitudes towards health actors if the Rohingya trust the facilities. Other behaviours, however, may still take longer to change, such as shame associated with reporting symptoms, fear of consequences for this, and the erosion of trust during the pandemic.

Recommendations

- **The response should re-evaluate its priority focus on testing and continue to focus on building trust and what Rohingya understand as good quality treatment.** During the period under consideration, the Rohingya were largely opposed to testing and treatment-seeking behaviour was low. Given the perceptions and sentiments outlined in this report, approaches to building trust and encouraging health-seeking behaviours could be encouraged by focusing on what the Rohingya people have requested since the beginning of the response: good quality treatment for their health problems. This is not to suggest that testing should be abandoned, but to consider where the emphasis of the response should be placed and what indicators should be used to measure "success". Community trust cannot be measured through testing rates alone or simple indicators.
- **Community surveillance models, monitoring of deaths, and symptom surveillance should be reconsidered in light of evidence that suggests people intentionally hid potential COVID-19 symptoms or deaths.** People chose not to disclose symptoms or report deaths of persons with COVID-19 related symptoms. Instead, they took proactive measures to hide what was happening because they did not want to engage with the response. Rohingya currently have different ways of reporting deaths of people with COVID-19 symptoms in order to avoid further questioning and scrutiny of these cases. This indicates that prevailing models for monitoring these indicators at a community level need to be reviewed. Applying more pressure or trying to "investigate" events may frighten people, resulting in them hiding or fleeing from such efforts. Both have been reported occurring during this research.
- **Revisit and review messaging and community engagement activities about the pandemic in the camps.** People may be unaware that reinfection is a possibility or may become complacent to real risks if they believe the pandemic to have passed through when it has not. There is also a need to revisit approaches around information dissemination; community engagement approaches need to be rethought with an emphasis on trust building.
- **Empower more Rohingya within the response,** especially in avenues where they can articulate their opinions and desires without intermediaries. The narratives, reports, suggestions, and beliefs of the Rohingya should not be treated as "uninformed." More platforms are needed for different Rohingya groups across the response. This is evident in the fact that the Rohingya appeared to mistrust many actors, resulting in them not disclosing the information contained in this report.

Methodology:

This report is based on independent field work conducted by 16 Rohingya CwC researchers between 25 May (Eid al-Fitr) and 25 June 2020. Additional verification of their testimonies and reports was conducted by the CwC Technical Officer to corroborate information with direct sources. The information contained in this report should be used to inform additional avenues of inquiry to investigate the current stage of the outbreak and to contribute to the response's understanding of the wider picture. It is not a definitive explanation of events or verified scientific reports.

The team has received over 150 hours of training in qualitative research and data collection, including participant observation, "thick description", and open and semi-structured interviews. The information was collected through open discussions with people in their communities around the developing events and is the result of extensive field notes and informal interviews with nine mosque committees, members of their local community, key informants in the camps, and discussions with other Rohingya in the camps.² Weekly meetings were held between IOM's CwC team and the Rohingya researchers to discuss and explore these reports and developments. The unstructured nature of this edition is due in part to the current situation in the camps, and in part to the Rohingya's preference for informal, open-ended discussions.

The research style resulted in the disclosure of other terminologies and euphemisms used for COVID-19 when discussing events during that time. These euphemisms became common practice as people were hesitant to directly report symptoms given their understanding of the implications. The symptoms described in the report are from the informants themselves, not medical professionals. It is also important to note that Rohingya refugees were willing to share their stories now because they believe their community has recovered from COVID-19 and they are no longer at risk of family separation or being transported to isolation or quarantine facilities which they believe are unsafe.

To ensure the safety of the Rohingya who chose to speak with the researchers and the CwC team and to treat them with respect and dignity, the researchers approached people's decisions as ones informed by their life experiences instead of as irrational fears, rumours, or "misperceptions" of a situation. In the consent process, Rohingya researchers affirmed people's right to choose whether to share personal information and clarified that the information shared would not be used to pressure them to seek treatment, testing,

quarantine, or isolation. It was stressed that no identifying information would be shared externally and, as such, this information has been omitted from this report.

Meetings between IOM's CwC team, researchers outside the camps, the Rohingya researchers, and other key informants were kept to a minimum and involved physical distancing and other relevant protection measures to ensure ethical data collection and the safety of everyone involved. The Rohingya researchers limited their travel to their localities. All staff and enumerators have had training on PSEA, confidentiality, consent and data protection protocols.

Limitations:

As standard face-to-face consultations through FGDs and KIs were not possible due to transmission risk, this edition was gathered through phone conversation and small group interviews with key informants and Rohingya researchers. The informants cover all areas within KBE, but not all camps are represented therein. Further research needs to be done in non-surveyed areas of the camps and within different demographic groups.



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 a select number of Rohingya living in camps. It should not be read as a definitive account by the Rohingya on COVID-19 nor of their perceptions of the humanitarian response to COVID-19 across all camps.

² Mosque committees are all-male committees that oversee the governance of the mosque and play a social role within the community. Generally, they are made up of 4-6 members. For a longer discussion of mosque committees

and their role in Rohingya culture, please see IOM's "Clan, Community, Nation: Belonging among Rohingya living in the makeshift camps".

The Story of the Epidemic in the Camps

The first case of COVID-19 in the camps was officially reported on 14 May 2020 in the northern camps of KBE.³ Leading up to this time period it should be noted reports of high-risk activities such as the sharing of masks or Tarabi prayers. This is in addition to overcrowded living conditions, and the reliance on public, and often overcrowded, hygiene infrastructure including toilets, bathing facilities and water points. Rohingya have reported from the beginning of COVID-19 prevention measures their inability to physically distance themselves from each other in the camps. Tarabi prayers are a key activity during the month of Ramadan, involving mass communal gatherings either in homes or in camp mosques. These prayer sessions continued throughout the period under consideration – restrictions surrounding prayers in mosque were relaxed towards the end of Ramadan by the Bangladeshi government. Researchers also reported that the sharing of masks to enter distribution areas became common practice, with some individuals renting out masks for 10 Taka outside distribution areas.

In the first week after Eid, Rohingya researchers began reporting deaths from COVID-19 related symptoms across the Kutupalong portion of the camps (northern part of KBE). Later reports attested to a similar series of COVID-19 related symptoms appearing in the Jamtoli area around the same time. These reports were received by other actors within the response⁴ and consisted of accounts of people suffering from both fever and aches, with fewer reports of people with difficulty breathing. Slightly prior to Eid, there were cases of people falling suddenly ill and dying unexpectedly from unknown causes. One such case was that of a Rohingya volunteer well-known for his work and advocacy in the camps. His death was not initially attributed to COVID-19 but has since been acknowledged by some medical practitioners as a potential outcome of the virus.⁵ During this time, the researchers made at least ten independent reports of deaths in their sub-blocks or among relatives from flu-like causes. One volunteer said, “several funeral processions passed in front of my house down the main road of Kutupalong every day.” While the average death rate within the camps is unknown, of the 13 sub-blocks the Rohingya researchers live in, eight have had deaths since Eid, whereas only two had deaths in the period between March and Eid.⁶

³ <https://www.unhcr.org/news/briefing/2020/5/5e42044/public-health-response-rohingya-refugee-settlements-alert-first-coronavirus.html>

⁴ Reports of a “flu” were noted and discussed by Site Management, CwC agencies, and other critical actors within the response for example when they occurred.

Many humanitarian and government actors responded to these reports, attempting to verify information to ensure that planned health interventions could be implemented to reduce spread of COVID-19. They sought to quarantine people who had been exposed to the virus and isolate and treat those who tested positive. These reports were referred to Site Management agencies by the CwC Technical Officer, who were unable to verify deaths caused by flu-like symptoms. Many actors receiving these reports thus concluded that they could be attributed to the seasonal flu, potentially triggered by the first monsoon rains. This was also the explanation offered by many Rohingya at the time given that seasonal flus accompanying the monsoon are not uncommon.

At the time, graveyard monitoring reports had not yet been systematically collected and no reports of a spike in the number of burials were received. In a high-transmission scenario presented by John Hopkins University, projections for the pandemic within the camps estimated an excess of 2,000 deaths.⁷ It was believed that if COVID-19 was in the camps, the number of people with difficulty breathing and the number of fatalities would be difficult for the population to hide given close level of examination across the camps. However, by the second and third weeks of June, Rohingya researchers continued to insist that such cases were prevalent and that they were COVID-19 being reported as “the flu”. They noted that there were more people sick in the southern parts of the camp, including Jamtoli and Balukhali areas.

Reliable and consistent reports from numerous sources, however, lend to the credibility of reports of suspected COVID-19 deaths that were not reported through official channels. People making these reports could name the person who died, their age, gender, symptoms prior to death, location, and so on. They also believed that their own symptoms or those of their relatives during this time matched accounts of COVID-19. These included fevers lasting more than a week, severe aches and pains associated with moving, and difficulty breathing. In some cases, Rohingya researchers reported direct accounts of funerals or invitations to funerals and could name the family and other associated details with ease or verify this with the concerned party. Their stories were shared with a sense of relief that, while people died, the “Coronavirus has passed.” People shared and remarked openly that they no longer fear the virus because they were sick during this time. The

⁵ <https://www.washingtonpost.com/health/2020/04/24/strokes-coronavirus-young-patients/>

⁶ As reported on the 28th of June.

⁷ Truelove, Abraham, Altare, Azman, and Spiegel. “COVID-19: Projecting impact in the Rohingya Refugee Camps and Beyond”. John Hopkins University, March 25, 2020

anecdote below is paraphrased from a longer discussion and suggests the virus was both widespread and fatal.

“Informant: In my Mazi-block, all except 7-8 households became sick at the same time in the second week of June. During this time, everyone had fever and other coronavirus symptoms and eight people in the area passed away from different causes. Some of the mosques in our area closed to stop the spread while others continued.”

Interviewer: What did people do when they were sick?

Informant: Many of the elderly people did not want to go to the clinics and many sick people went to the local pharmacy. Quack-doctors came to our area and prescribed medicines. Now only people with non-coronavirus symptoms are going to the clinics because we heard that one person with symptoms was taken to isolation outside of the camps.

Interviewer: Are you able to tell me more about specifically who died and how?

Informant: Four of the people were from my Mazi block. Of the people in the area that died, one was elderly man, one elderly woman, and two boys, seven and ten years old. Another person suddenly died who was a friend of mine around my age [20-30] – he lived in the neighboring block. All the people who died had fevers. I can only not say for one of the boys what his symptoms were or whether they had rashes. I can follow up with more information if needed.

Interviewer: How long did the fevers last?

Informant: Everyone had fevers for seven to eight days – it lasted a long time. Most of the people recovered on their own though some of the elderly are still having difficulty breathing. My elder brother was sick with fever and severe pain throughout his body, I asked him to go to clinic, but he refused to go. My grandmother also had a cough.”

Other reports were similar in detail and involved accounts from people who disclosed that family members or extended relatives had died from COVID-19 related symptoms. As Rohingya culture requires that extended family or *ghushi* (clan) members be invited to funerals, the researchers and informants were aware of deaths across various parts of the camps; family networks were spread out across the camp during the influx.⁸ Some reported that they attended funerals. Researchers and informants also disclosed that some among

them had experienced extended fevers which lasted over a week and had prevented them from working during this time. However, they were only willing to discuss these reports given the amount of time that had passed since symptoms were experienced.

The Rohingya researchers spoke with mosque committees from nine blocks in Kutupalong camps and recorded the number of deaths that had occurred since the beginning of Ramadan. All nine blocks reported widespread flu-like symptoms. When asked to estimate the percentage of households impacted, the majority reported between 70-80% of households in their block had members within their household with flu-like symptoms. The lowest estimate reported by a committee informant was 40%. Of the nine blocks consulted, seven reported deaths from COVID-19 related symptoms, all of which went unreported to humanitarian actors or through official Government of Bangladesh channels. Of the two subblocks where there was no reported COVID-19 related deaths, one sub-block did report a death reported under a pseudonym that was later reported to be used by the Rohingya to avoid disclosure of deaths with COVID-19 related symptoms. A larger sampling is being conducted by the team to provide to epidemiologists for further review.

In addition, the Rohingya researchers themselves recalled a total of 13 people who they knew directly, or were relatives of people they knew, who died from what they believe to be COVID-19. They explained that five of the 13 reported deaths had comorbidities and over half of those deaths were people over the age of fifty. Most of the deaths detailed above reportedly occurred between the second week of May and the second week of June. However, the earliest suspected COVID-19 death dated to the last week of April.



⁸ See IOM’s “Clan, Community, Nation: Belonging among Rohingya living in the makeshift camps”

The Story in Perspective

Early editions of the *COVID-19 Explained* series have documented the lack of trust Rohingya have in health care providers in the camps for various reasons.⁹ The level of distrust in health facilities is not only present in the camps, many COVID-19 isolation and treatment facilities across Bangladesh are currently underutilized despite rising COVID-19 cases with many sources reporting report fear of hospitals and facilities being a major contributing factor to the lack of reporting and usage of government facilities.¹⁰

For the Rohingya, the dynamics of the health response and the reasoning behind its different elements remained somewhat unclear. For example, it was not clearly explained to the Rohingya that after a certain number of cases are discovered, a different modality for providing care will be implemented – homebased care. Information and communication campaigns focused on what information to disseminate to the Rohingya at various stages of the response instead of how the response planned to address and respond to the pandemic at its different stages. Rohingya responders and community members fundamentally disagreed with some aspects of the COVID-19 response. For example, although principles of confidentiality and consent were widely announced and agreed upon, there were multiple incidents of patient details being revealed to the wider public when taken to quarantine or isolation facilities.¹¹

There was also a failure to explain the response plan and at each step of the process. Many Rohingya who were the first to be tested did not understand why or where they were being taking for testing, isolation, or quarantine.¹² This is not the case in all instances or for all actors, but the Rohingya rapidly share information through family and other networks. This is both a historical and present-day means through which they gather information to make important decisions quickly, whether the decision is to flee to Bangladesh because of reports of violence in faraway villages, or whether it is to avoid testing due to negative reports around the COVID-19 response. The poor understanding of these response measures magnified the negative perceptions of the response and adverse experiences in health facilities were shared at higher rates than positive experiences, even when people’s own testimonies revealed that experiences are indeed both positive and negative.¹³

Further research should be done to determine how and whether these experiences are changing over time. It is also important to highlight confusion around the rapidly changing guidance and governance of the health response by Camp-in-Charge (CiCs) and humanitarians, such as whether lockdowns were mandatory after confirmed positive cases as elsewhere in Bangladesh. This confusion strongly impacted the Rohingya’s understanding and opinion of the health response.

When exploring perceptions around the terms “quarantine”, “testing”, and “isolation”, it was clear that many Rohingya did not understand these terms in relation to the response, nor their purpose and implementation even when they were explained. Major differences between the Rohingya understanding of disease and disease transmission and Allopathic medicine remain.¹⁴ However, it should be noted that the Rohingya do understand the general guidance on preventative measures that was emphasized in the early phases of the response.¹⁵ Additionally, the general population still lack information in details on what to expect and the process across all steps of testing, quarantine and isolation prior to these experiences. There are challenges in adjusting plans to the particular needs of families and individuals. Below is a description of the prevailing perceptions about each of these terms, many of which have already begun to be addressed by the response:

Testing: Many Rohingya refer to temperature guns as “Coronavirus checkers” that detect COVID-19 as opposed to instruments to measure temperature. Some people have directly requested that IOM CwC provide such “testing equipment” to them so they can test people within their communities. They also requested that “Coronavirus tests” be done in the camps by trusted health agencies, indicating the want for “immediate tests” that did not require people to leave their homes during the testing period. This indicates a lack of understanding that testing can only be done by the Government of Bangladesh, requires specialized equipment, takes two days or longer to process if the sample is not adequate for testing, and involves an uncomfortable nose-swab. Testing cannot be done within the communities and, for a significant period of time, the Government of Bangladesh required quarantine in an official facility until results were confirmed.

Reporting and referrals: Instead of health practitioners asking patients what their symptoms were, they were asked whether they had fever or a cough. Many people simply responded “yes” because they wanted medicine, which is often associated with better

⁹ For more information please see earlier editions of *COVID-19 Explained* in particular Edition 6: Have you ever walked a mile in their shoes?

¹⁰ <https://www.aljazeera.com/news/2020/07/bangladesh-coronavirus-patients-shun-government-hospitals-200713054913016.html>

¹¹ The issue of data confidentiality and COVID-19 testing has been discussed at length by humanitarian operational see Protection Sector meeting minutes from 19th May 2020 here.

¹² For more on this, see earlier *COVID-19 Explained* Editions

¹³ *COVID-19 Explained* Edition 6: Have you ever walked a mile in their shoes?

¹⁴ For more on this, see earlier *COVID-19 Explained* Editions

¹⁵ See *COVID-19 Explained* Edition 5 for more information

treatment. Among the Rohingya, responses are best elicited through open ended questions as opposed to yes-or-no questions, especially when there is the belief that answering “yes” will cause less trouble or allow easier access to assistance. A bias towards positive or affirmative answers is an identified challenge in quantitative assessments within the response. One Rohingya researcher reported also that people were “taken” for testing and quarantine while waiting for their test results despite having no symptoms and simply seeking medication from the clinic.¹⁶ This affirms that the Rohingya did not fully understand each step of the process.

Quarantine: The official purpose of quarantine is poorly understood by the Rohingya in the camps, even educated Rohingya youth who received orientation and training on the differences. “Quarantine” and “isolation” were conflated and used interchangeably and, when distinguishing between the two, people often did not understand the differences. There was also a preponderance of reports regarding the belief that COVID-19 response efforts were largely a way for organizations to make money rather than provide care to the Rohingya. People who were quarantined and returned to the camps shared stories that dissuaded the population’s participation. It should be noted that there were more positive accounts and reports of quarantine experiences than negative. However, these were overshadowed by reports from the people who were initially quarantined, including a number of “boat survivors” after they returned from a failed sea voyage to Malaysia, many of whom had not seen their families after a traumatic two-month journey and felt “imprisoned” upon return.¹⁷ Some reports suggested that food provided during quarantine was inadequate and did not meet the needs of quarantined people.¹⁸

“Those in the quarantine center report it’s like jail. Some people said they were given less food than they needed and there was a visit planned by some managers to the facility. Before the visit, people were told what to say when asked questions, and during the visit they were given extra food which was then reduced after the managers left.”

“We interviewed a woman in a quarantine center at the very end of her quarantine. When we went to interview her the staff at the clinic were scolding us and saying, ‘why are these Rohingya here don’t they know this isn’t open to them.’ When we told them, we were here to interview a person, they then were polite. When we met with

the woman, she opened up to us. She told us that it was the first time she had been given biscuits and that the people at the facility told her to say that they gave her two awareness sessions a day. They didn’t talk to her at all, but they did bring her medicine when she told them she had neck pain. Ultimately, though, she said it was okay being in quarantine.”

“Guards are there yelling at people, telling them they aren’t allowed to see visitors and they don’t have phones to call their families. The only good thing is that they can pray a lot.”

“When people were in quarantine, they [those in charge of the facility] took many photos of them. People don’t know what the photos were for, but they say organizations are using Coronavirus to make money for themselves and are only giving us a small NFI kit at the end of quarantine.”

Isolation: When discussing isolation, it was said that “people should be taken to a hospital or a place where they can get treatment”, highlighting confusion around the purpose of isolation and how it differs from a regular hospital.¹⁹ The conflation of quarantine with isolation, and perceptions on what was expected from Isolation & Treatment Centres, was largely shaped by experiences recounted from people in quarantine facilities. Moreover, people taken to isolation centers reported that they did not receive any special medication, leading them to believe that they were taken there to see whether they would die instead of for treatment. The Rohingya refer to isolation either as “isolation” or “sira zaga” (separate land/place), many understanding it to mean “being sent to die alone.” One volunteer reported that when he asked his mother to go to the clinic because she had a high fever and cough, she said “you don’t want us to stay at home during Ramadan” because her understanding was that she would be isolated/quarantined against her will and her children knew this. This confirms the notion held by the Rohingya that isolation facilities were used to separate families and “send people away”.

The Rohingya reported many negative, stigmatizing, undignified, and difficult experiences around the testing and treatment process. Early on, people felt forced to test, were placed

¹⁶ Because the Rohingya use quarantine, isolation, and treatment terminologies differently than their official medical definitions, it is often difficult to distinguish what specific practice they are referring to. In this case, the person was referring to the practice of being forced to separate in a facility while their test results were processed.

¹⁷ See <https://www.npr.org/2020/04/16/835689913/nearly-400-rohingya-rescued-from-boat-near-bangladesh-after-2-months-adrift> for an example of reporting regarding this incident.

¹⁸ It should be noted that the “boat survivors” were the first residents of the newly established quarantine facilities. Partners acknowledged the difficulties with the initial food support system and changed it at the end of the quarantine period. However, despite the rapid changes, initial reports went a long way in shaping perceptions of these facilities even as issues were quickly addressed.

¹⁹ Discussions with Rohingya Researchers.

into isolation or quarantine against their will,²⁰ or felt uninformed about the process. This largely shaped public perception of these events.²¹ CiC's imposed lockdowns of sub-blocks within the camps also meant that some Rohingya were unable to receive food and other assistance.²² This has led to a fear of lockdown as a result of positive tests or discovered symptoms, with households fleeing areas where confirmed or suspected cases were identified or when their neighbors were suspected of being sick. There were also reports of sub-blocks extorting the families of people who were quarantine, saying that they would only be released if they family paid a bribe. All of this has contributed to, and built upon, the Rohingya's already high levels of fear and mistrust.

It is important to note that there were reports of positive experiences where facilities were good and there was a high level of care. Based on these reports, the Rohingya noted that they would be willing to go to that particular facility. For example, one volunteer commented "when an older person at the facility could not go to the bathroom on his own, they were cleaning him when he had soiled his bed." Another reported that people at the clinic were given phones and tablets to speak to their relatives whenever they wanted throughout the duration of their stay. They also reported that if more "good facilities" were created, they would be used.

The Hidden Story

Reports of flu-like symptoms coincided with early reports of negative experiences with testing, poor treatment at quarantine, health and isolation facilities, difficult experiences with lockdowns, and general fear and mistrust of health facilities. Often expressed was the belief that they may be killed or left to die. Between 1 and 23 June, an estimated average of 6 individuals per day from Rohingya refugee population consented to testing, down from an average of 11 people per day in May. This is despite the increase in capacity at the end of May with the installment of an extra PCR machine in the field laboratory in Cox Bazar.²³

The low number daily tests was partially due to a requirement by the Government of Bangladesh that the Rohingya quarantine in official facilities away from their families if they

were tested. If they tested positive, their families and others would also be obliged to quarantine, and the confirmed case would be moved to an Isolation and Treatment Facility. For the reasons mentioned above, early experiences of quarantine and isolation and a history of persecution meant that this was a terrifying proposition for many Rohingya.

The total number of Acute Respiratory Infections (ARI) cases reported in EWARS by 23 June was under 5,000 cases, compared to 17,000 during the same time last year.²⁴ According to the WHO, a two-thirds reduction of total ARI consultations likely indicates changes in Rohingya health seeking behaviors. In addition, since the COVID-19 response began in the camps in late March, the total number of consultations dropped over 50%.²⁵ These numbers indicate a strong trend among the Rohingya not to test or treat. This is neither an accusation nor blame; there are many variables, from historical experience to contemporary developments, that shape the Rohingya's aversion to seeking treatment or testing for COVID-19. It also needs to be stressed that this decision is not related to a particular actor or sector and is more widely related to feelings around reporting these issues openly to "humanitarians" as a broad category of actors, international and Bangladeshi. Collective history and lived experiences in Rakhine and in the camps, combined with how early positive cases were handled, led many Rohingya to conclude that seeking treatment was less favorable than the consequences of not seeking treatment.

Although the Rohingya may not have fully understood the benefits of testing and isolation in the same way as the humanitarian response, they made this decision by weighing the risks and benefits associated with reporting symptoms. It was noted that while the reasons for not testing were many, the reasons to test were few and the official reasons provided were generally not agreed with, accepted, or understood by the Rohingya. The value of physical distancing and quarantine are nearly impossible for the Rohingya given the circumstances, and have been rejected and complained about since the beginning of the response given their cramped conditions.²⁶ Many Rohingya noted that they were unable to physically distance, never wanted to separate from their families regardless of the potential consequences, and so on. Therefore, attributing their decision to a lack of understanding of the public health reasons for testing and isolation ignores the reality that the Rohingya have simply come to different conclusions around how they think the pandemic should be

²⁰ This was apart of the overall Government of Bangladesh requirement for people who were positive or potentially exposed to COVID-19.

²¹ See Amnesty International Report <https://www.amnesty.org/en/latest/news/2020/06/protecting-rights-of-rohingyas-need-international-cooperation/>

²² Report by Rohingya researchers in Kutupalong

²³ The total number of tests conducted for the refugee population is 536 since they began in March 2020, compared to 14,512 tests in the host community during the same timeframe (WHO 28/06/2020). For more information on PCR machine and testing processing capacity please see WHO SITREP from 3rd June 2020.

²⁴ See Epidemiological Highlights Week 25, EWARS, WHO, 21/06/2020
<https://reliefweb.int/sites/reliefweb.int/files/resources/ewars-w25-2020.pdf>

²⁵ Ibid.

²⁶ For more on this, see earlier COVID-19 Explained Editions

managed – conclusions which differed significantly from the planned health response. How the Rohingya would like to manage the pandemic is yet to be explored; epidemics and public health are largely government-led and, in this case, led in partnership with humanitarian stakeholders. How the Rohingya believe public health should have been approached requires further exploration to be better understood.

When exploring why the wider humanitarian response was largely unaware of what was being shared, it appeared that the Rohingya, as a group and in an uncoordinated manner, effectively boycotted humanitarian-run facilities, hid symptoms, and refused to be tested because of their fears about how they would be treated.²⁷ When asked how it was possible for this to go unnoticed given the range of actors investigating potential cases and monitoring the situation in the camps, the Rohingya explained that they simply did not tell others they were sick, did not seek treatment at clinics, and even hid symptoms from neighbors and family members to avoid complications. Rohingya researchers pointed to long lines at pharmacies and unofficial clinics as evidence of the pandemic. When people were asked about symptoms or deaths, they simply reported symptoms or causes unrelated to COVID-19.

“When people are found with a fever when they go to collect food at a distribution, they run away, and nothing is done. This way they don’t have to deal with any problems.”

“When people from humanitarian agencies come to our shelters and ask us if we have symptoms, we tell them no one is sick, and they go away.”

“When everyone was sick, people from our village [in Rakhine] in our Mazi block raised money to help each other pay for visits to the fake doctors.”

“Everyone is going to the fake doctors, but we are worried because they don’t ask if you have other illnesses and they are giving many medicines.”

Rohingya communities achieved this through existing and historical systems of social control, with testing becoming synonymous with “a shameful action” that might bring harm to the community. Reporting symptoms became synonymous with reporting to the authorities something the larger community wanted to keep secret for their own protection. This system does not stem from any overarching leadership, but from localized

communities and family groups who decided to manage the issue themselves. People internalized these feelings and went to great lengths to not disclose what was happening.

“It is a sort of shorom [shame] to report symptoms since it might cause harm to your family or mean your community will be lockdown.”

“My grandmother started having a cough during this time and my mother was yelling at her and saying ‘Don’t let others hear you coughing. People will report you. Why are you giving trouble to my sons? They will come and take my sons away from me! Why are you bringing these problems upon us?’ She used to go to visit doctor once a week because her health is poor but now, she has not seen a doctor for many weeks.”

These mechanisms that enable wider and familial social cohesion around decision-making have been documented in other IOM CwC research.²⁸ These systems were important forms of social safety that kept communities safe from discrimination and oppression in Rakhine, where they were routinely forced to hide information from authorities. These historical behaviors that provided the Rohingya with safety from outside threats are still in play, and recent circumstances reinforced a sense of unity against sharing information with outsiders.

Non-disclosure of symptoms, however, does not explain how deaths were not revealed to Site Management agencies or other actors. Rohingya researchers gave clear explanations for how people were able to report deaths under other causes, ensuring their dismissal as non-COVID-19 related. These reports were cross confirmed by the IOM Technical Officer who received similar information. There was an apparent willingness on the response’s behalf to accept other reported causes of death when Rohingya provided them. There were also other reasons, such as the sharing of graveyards between host and Rohingya communities, which explained why some graveyards that do not appear to be full actually are for the Rohingya.

“The four people who died in my Mazi block were buried in Camp 19. They just reported that the person had been sick for many years. Many people said that the people were having [false symptom] and that they died from this. Other times people just said the person died from [other causes].”

“Some Rohingya volunteers that were asked to collect information on the number of deaths in our camp could not read or write since they had bribed to get their positions

²⁷ By uncoordinated, it is meant that these actions were discussed openly among Rohingya or led by a particular leader within the camps. Instead, it was a strong general sentiment and response developed from shared historical experiences, cultural beliefs, and social systems.

²⁸ See IOM’s “Clan, Community, Nation: Belonging among Rohingya living in the makeshift camps”

and faked their education certificates. Rather than asking people, I found out they made up deaths and symptoms of people since the beginning of the year and submitted the reports.”

“People in Kutupalong are buried in the host community graveyard. There, the graveyard is divided and one host community political leader allows Rohingya to bury their dead in one half of the graveyard but in the past month there have been so many deaths that that part of the graveyard is now full and people can’t bury their dead there. They have to be taken to other graveyards”

Through discussions with Rohingya volunteers and key informants, it was disclosed that many among them had also symptoms, but few reported them because of the risks associated in seeking testing and the perceptions surrounding treatment and its effectiveness.



Many people reported feelings of relief now that the experience was “over” for them, highlighting the degree to which they believe their symptoms matched what they understand as COVID-19. If people start to experience COVID-19 related symptoms, there are now set treatment procedures prescribed by unofficial doctors and clinics operating in the camps. Some people reported that these medicines are sold in a package at an established rate of 3,500 BDT and requested that humanitarians advocate for the price of these medications to be lowered. Poor understanding of the available care for people who have difficulty breathing remains, and one informant noted that “after the first ambulance took away people reporting symptoms, people stopped going to clinics.”

The Rohingya have overwhelmingly decided not to seek treatment or to test, choosing instead to manage COVID-19 themselves. This decision appears to have been based on widely shared cultural and communal sentiments (such as not wanting families to be separated, or fear of death in hospitals) that reinforced existing behaviour. A prominent

imam reported that, “Humanitarians have come to tell me to tell people to test and seek treatment if they have symptoms, we understand that we need to go wear mask, maintain social distancing. But people do not listen to us. They say, ‘you go to meetings [with humanitarian agencies] that is why you are also saying to us the same things as them.’” Even traditional social leaders in respected positions appeared to have been rejected because of their association with humanitarian information campaigns; the community was mostly united in its opinion.

The Beginning of the Story

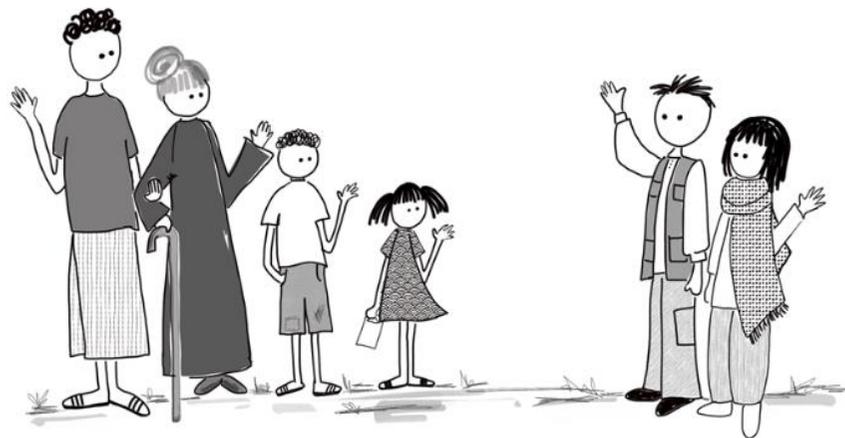
Being killed in a medical facility has been a persistent fear from prior to the outbreak of COVID-19. The COVID-19 Explained series has tried to better understand where these fears arise from. Such fears have largely been treated as product of the violence and persecution experienced by the Rohingya in Rakhine without fully understanding what many Rohingya were trying share with outsiders. This research, too, has avoided such exploration because the recollections are painful and many people are unwilling to revisit such events. However, when asked whether people still thought they would be killed in isolation centers, some shared the following:

“People don’t think this as much now, but do you know why we think this? It’s because they did this in Rakhine. Rohingya people in the hospital in Maungdaw township used to all die on the same night and have a similar chemical smell around their mouth afterwards. My uncle was in hospital on one of these nights. This was in 2016.”

“I was with my sister at the hospital once when a group of Rakhine [Buddhists] came into the hospital and said to the nurse ‘where are the Rohingya we are going to kill them.’ She told them to come back at night. That is when I ran away with my sister. They [Hospital Staff] tried to stop us, but we ran away after it was dark. Outside the hospital, the Rakhines tried to stop me using nashang kru, nai chaung cho [nunchucks] and that was how I got this scar on my hand. I went to [my friend’s] village nearby and the next day many Rohingya at the clinic had been killed and they buried the bodies the same night.”

“Two people had fought over money that was owed. The one person who owed the money beat up the other person and he was taken to hospital. The person who owed money then went to pay the nurse to kill him. The doctor left the patient in the evening and said he didn’t need anything more, but the nurse gave him an injection in the night according to other people.”

These accounts came from key informants living in Maungdaw township interviewed by the CwC Technical Officer. One person recounted that the hospital there repeatedly buried bodies in shallow graves that were often dug up by wild dogs. A history of abuse within medical facilities appears to be prevalent and has been documented in other sources.²⁹ In IDP camps in Rakhine, stories of doctors and health facility staff killing patients upon orders from authorities were commonly shared and are a very real fear held by many. As a result, people reported paying trusted individuals to accompany them or a family member to the hospital because they were so afraid that they would be intentionally killed during their visit. This was such a common occurrence that some Rohingya professionally worked as escorts for sick people – bringing them to, and returning safely from, hospitals.³⁰ Evidence of killing by injection is not as well documented as other atrocities committed against the Rohingya; however, the fear and behavior that has resulted from these stories is well documented and very real.³¹ People also explained that the Rohingya in some countries, like Saudi Arabia, have gone into Isolation and Treatment Centers after testing positive and were never heard from again, presumably because they died or, as some believe, “were killed” and no-one has informed their families in the camp.



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The Stories Left to Tell

This report is by no means a full explanation to what is currently happening. Even if the issues raised in this paper are true, many questions arise. For example, if the Rohingya were able to hide symptoms and report COVID-19 deaths something else, projections still suggest a far greater number of people should have died (although the true death rate remains unknown and likely will never be fully known). It is possible that the pandemic has not progressed past its initial stages and that these reports represent initial clusters of epidemic hotspots or another influenza-like illness. However, this fails to explain the situation given that these reports have come from locations across Kutupalong, Balukhali, and, to a lesser extent Jamtoli.

This edition largely reiterates the point that perceptions continue to shape the Rohingya’s decisions related to COVID-19 and that these perceptions need to be placed at the center of the response if meaningful trust and changes will be built. Early accounts of experiences of quarantine and isolation facilities will persist regardless of whether they are “factually true.” Equally important now is the perception and understanding that COVID-19 has “passed through the camps” and did so quite some time ago. While these reports alone are insufficient scientific evidence, Rohingya need to be trusted in their accounts and have them treated as credible if trust is to be built between humanitarians and Rohingya. There may be other pieces of these accounts that are not included in this report or are still largely unknown. Even if their perception that COVID-19 has passed through the camps is not accurate and actually what happened was a seasonal flu, then there will need to be a concerted effort to shift people’s mindset that this was indeed not the case. For now, the story being told is that COVID-19 is largely “finished” in many parts of the camp.

It is clear that a large section of the population, without hierarchal leadership, effectively decided not to seek treatment or test because of their concerns and shared histories. The Rohingya will not seek testing or treatment unless there are many changes in the provision of care. Even if these changes occur, it likely that people will take some time to change their behavioral patterns given the contemporary and deeper underlying historical experiences shaping this behavior. More work needs to be done to consider how these past experiences

29 See Allard K. Lowenstein, 2015, ‘Persecution of Rohingya Muslims: is Genocide occurring in the Myanmar’s Rakhine State? A Legal Analysis’, International Human Rights Clinic, Yale Law School, prepared by Fortify Rights, retrieved 27th of June 2020, https://www.fortifyrights.org/downloads/Yale_Persecution_of_the_Rohingya_October_2015.pdf
Human Rights Watch, 2013, “All You Can Do is Pray” Crimes Against Humanity and Ethnic Cleansing of Rohingya Muslims in Burma’s Arakan State’, <https://www.hrw.org/report/2013/04/22/all-you-can-do-pray/crimes-against-humanity-and-ethnic-cleansing-rohingya-muslims>,

30 Galache C, 2020, ‘The Burmese Labyrinth, A History of the Rohingya Tragedy’, retrieved 27th of June 2020 <https://www.versobooks.com/authors/2421-carlos-sardina-galache>

³¹ Ibid.

continue to influence dynamics within the response. It is also important to bear in mind that the Rohingya chose not to disclose what was happening to anyone, not just health facilities but the entire range of actors engaged in the COVID-19 response, including humanitarian agencies they reportedly trust.

The Rohingya population has repeatedly asked to be listened to, believed, and treat with respect. They have asked to be given more spaces to express their opinions in open ended ways that match their needs and comfort levels. Their stories are difficult to tell, and in telling them they recount and re-experience both the stories themselves and the fear of being punished for speaking to outsiders. This story has been by the Rohingya researchers behind all editions COVID-19 Explained as a result of their honesty and determination to report information gathered through trust building, even when others initially dismissed the reports as unverifiable and unlikely.

The response needs to stop insisting on engaging with the Rohingya in a manner that fits into existing humanitarian norms and should start engaging with them in the manner in which they are most comfortable. The longer-term training of more Rohingya and their inclusion in decision-making at the response level would no doubt improve our understanding of the situation and the population's trust in the response in the future. If more Rohingya were equipped and placed in leadership positions, our understanding of the situation would likely be better, not to mention the population's trust in us greatly improved. The epidemiological science of what happened in the camps needs to be studied and reviewed. For now, pandemic remains, for many of the Rohingya, the will of Allah.



Dedicated to the Rohingya researchers who make COVID-19 Explained possible