RESEARCH BRIEF

Covid-19 Awareness, Preparedness, and Impact on the Most Vulnerable Groups among the Rohingya Community in Cox's Bazar

Ateeb Ahmad Parray, Rafia Sultana, Kazi Sameen Nasar, Saifa Raz,
Muhammad Riaz Hossain, M Shafiqur Rahman,
Bachera Aktar and Sabina Faiz Rashid

Background

Rohingyas are a Muslim majority ethnic group who have lived in Myanmar for centuries. They have also faced persecution in Myanmar for decades which has led to them fleeing the country towards Bangladesh starting in the 1970s (1). However, the largest influx into Bangladesh happened in August 2017 when almost 750,000 Rohingyas fled into the country and have since remained in Bangladesh (1-2). The Rohingyas, often referred to as forcibly displaced Myanmar nationals (FDMN), reside in makeshift shelters in 34 densely populated camps in Ukhiya and Teknaf sub-districts in Cox's Bazar district, one of the poverty-stricken districts at the south-east coast of Bangladesh where about one-third of the population is living below the poverty line (2). The Rohingya community is largely dependent on humanitarian aid from different non-governmental organizations (NGOs), international non-governmental organizations (INGOs) and United Nations (UN) organizations who provide basic services to them and most of these people don't have a minimal source of income (3). The COVID-19 pandemic poses a range of challenges in such an already fragile context after the first case of COVID-19 was identified in the Rohingya camps on May 14, 2020 (4).

To prevent Covid-19 in Bangladesh and mitigate its impacts, long-term transformative, sustainable, and inclusive interventions are required, particularly in humanitarian crises (4). To support this notion and to explore Covid-19 awareness, preparedness, and impact on the most vulnerable groups (MVGs) among the Rohingya Community in Cox's Bazar, BRAC James P Grant School of Public Health (BRAC JPGSPH), BRAC University conducted one participatory action research project in partnership with the implementation partner – Centre for Peace and Justice, BRAC University (5). BRAC JPGSPH was the led and research partner of this project funded by the International Development Research Centre (IDRC), Canada.

The overarching objective of this project was to identify the most vulnerable groups, explore their COVID-19 related knowledge, perception and practices and understand the impact of COVID-19 on their lives. This project aimed to provide critical evidence to support policies and interventions to mitigate the adverse impacts of Covid-19 on the MVGs in the Rohingya community.

This brief is a part of the Research Brief series published by the BRAC JPGSPH and presents research findings around existing knowledge, attitude, and practices regarding Covid-19 and its impact on the Rohingya community, focusing on the MVGs.

Study Settings

This research was conducted in ten Rohingya camps in the Ukhiya sub-district of Cox's Bazar, Bangladesh.

Rohingya camps are among the world's most densely populated (6). The camps in Cox's Bazar have a population density of 40,000 people per square kilometre on average, with some places reaching 70,000 (7). Physical separation is almost impossible due to the high population density, which increases the likelihood of transmission of any infectious diseases. The government of Banglad, in partnership with many national and international humanitarian organizations and law enforcement agencies, provides essential services to the Rohingyas living in the camps (4). They are dependent on rations for food and other essential commodities, targeted health care, and other essential services from government and non-government humanitarian aid agencies. However, the COVID-19 pandemic and its subsequent protocols disrupted all services, including essential services in the camps. Since they are dependent on humanitarian aid, many suffered severe catastrophic consequences of COVID-19 (8).

Methodology

This project employed a mixed-methods approach applying qualitative and quantitative methods sequentially. Data was collected from October 2020 to March 2021 in ten Rohingya camps purposively selected based on the intervention and coverage areas of the implementation partner - CPJ. Figure 1 depicts the methodology followed in the study. Research participants included adolescent girls and boys (11 – 17 years), adult women and men, elderly women and men, and persons with disabilities. Participants for qualitative assessments were selected using purposive, convenient and opportunistic sampling techniques. Two-stage cluster sampling technique was applied in the household survey. In the first stage, 10 Rohingya camps (project implementation sites) were purposively selected and the numbers of required households to be surveyed were proportionately distributed in each camp according to the population. In the second stage, households with at least one member from the most vulnerable groups were selected using the snowball and chain referral sampling procedure. The ethical clearance of this project was obtained from the Institutional Review Board (8) of the BRAC James P Grant School of Public Health, BRAC University under reference number- IRB-6 November'20-057. This research brief summarizes the triangulated key findings.

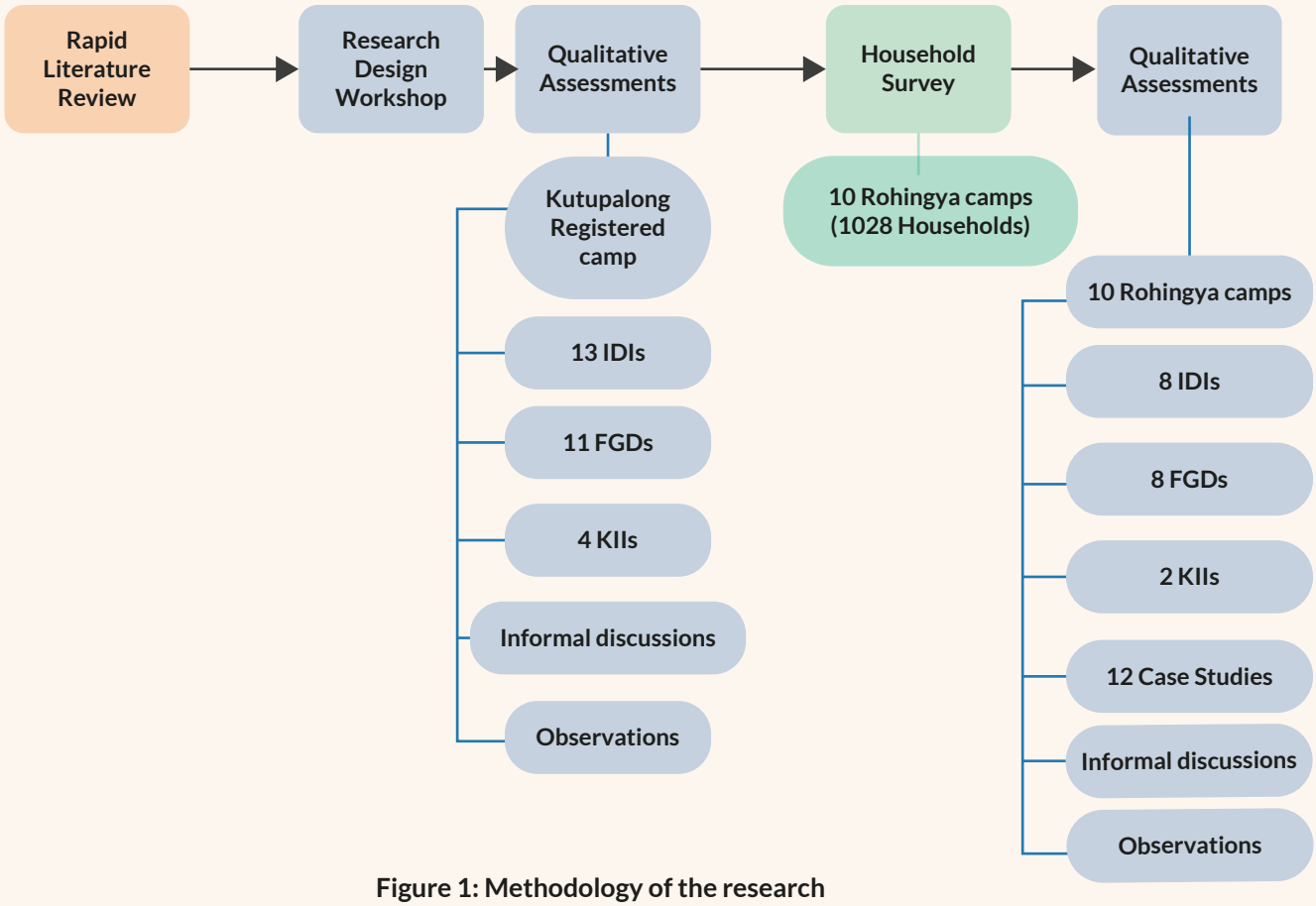


Figure 1: Methodology of the research

The Most Vulnerable Groups (MVGs)

The MVGs were identified applying a rigorous systematic approach including a rapid literature review, expert consultations made in a research design workshop conducted with local humanitarian actors – representatives from the Rohingya Relief and Repatriation Commissioner (RRRC) office, UN agencies, local NGOs and researchers, and informal discussions with Rohingya participants.

Types of MVGs and the MVG households included in this research

(includes both Qualitative and Quantitative samples)

347

Pregnant or lactating women

212

Elderly (Age>64)

382

Adolescent boy/girl (10-19 years)

327

Single female-headed Households

241

Person with disability

1028

Total respondents from MVGs

Perception about Covid-19

The qualitative data revealed various rumors and misinformation among the Rohingya community around COVID-19. The most common perception was that the increased sin of human beings resulted in the origin of Covid-19 in the world. More specifically, Covid-19 was termed as 'Allah r Gojob' (God's curse). Most of the participants, irrespective of gender, perceived that Covid-19 would not affect the 'practicing Muslims'. Being a Muslim community, most of them thus perceived themselves as safe and people from other faiths more vulnerable to Covid-19. In general, adolescent girls shared that they do not know the causes of Covid-19. This may be due to the religious restrictions on their mobility and their reliance on secondhand information from their male family members. Rigid socio-cultural beliefs and gender norms imposed on these girls by the Rohingya community hinder their independence rendering them dependent on men – brothers, husbands, fathers, etc.

Most of the qualitative participants thought that Covid-19 spread through 'batash' (air), more specifically 'wala batash' (air contaminated by Coronavirus, which people breathe in). Many adult male respondents mentioned that Covid-19 transmits as people came into contact with 'jibanu' (organisms) or people who would have fever, sneeze, or cough. Some of them added that physical contact with infected people such as 'manus hath dhore' (touching people's hands) and 'jhorai dhore' (hugging people) increased the risk of getting infected with Covid-19. Many elderly males and some adult female respondents believed that flies carried Covid-19 and spread it to humans, mainly when the flies sit on infected corpses and then sit on the food that other people ate. Similarly, survey respondents also mentioned that the virus spreads through sneezing (66.8%), coughing (52%), and close contact with/touching an infected person (49%).

Some participants, mostly the elderly, did not believe in the existence of COVID-19 in their community. One male participant with physical disability stated, *"If coronavirus truly existed, then why it has not come to our overcrowded area?"*.

There was a lot of anxiety, fears and rumors around the isolation centers being dark places, which are far away from their camps and patients have to stay alone and possibly die alone, without their family members. However, many participants could not share the actual location of the isolation centres.

> **"If someone gets corona then a red car comes and takes them away to an unknown place which is very far away from the camp. Only if the patient recovers, then he or she is returned to the camp otherwise we don't know what happens to that patient"** (32 years old female, Homemaker, FDMN).

Preventive measures and practices

Most common preventive measures reported by the qualitative participants included "washing hands with soap and water before and after eating", "avoiding drinking cold water", "maintaining cleanliness", "avoiding unhygienic food", "wearing warm clothes", "maintaining three feet distancing" while taking relief, and "staying away from crowded places". Female participants emphasized more on maintaining personal and household-level hygiene practices such as taking showers, wearing sandals on the toilet and washing hands after defecation, washing cemented floors with detergent or wet mob mud floor and cleaning the whole house once a day. Some home care preventive practices were also reported such as, drinking "rongcha" (raw tea), "gorom pani" (warm water) and "lebupani" (lemon water) to help prevent COVID-19.

Although many of the qualitative participants and a majority of the survey respondents knew wearing a mask could help them to prevent COVID-19, more than half of the survey respondents and many male qualitative participants admitted that they do not always wear a mask when going outside. The qualitative research found that the respondents usually wore masks for availing services, including rations collection, when attending NGO-led awareness campaigns and in the health centres (Picture-2),, mostly out of fear of punishment as not wearing masks would entail being denied rations.

Moreover, some participants across gender reported that they do not get enough water for frequent handwashing and hence do not use soap because they believed that the soap would consume more water. The field researchers found many non-functional handwashing stations, which were installed by the government or NGO, without water and soap supply.

> **"I really do not find wearing masks a pleasant experience as it feels very suffocating. That's why they (Community people) don't wear masks"**
> (40 years old male, Day laborer).

Covid-19 Vaccination

Although this research was conducted before and during the initial Covid-19 vaccine roll-out in Bangladesh from October 2020 to March 2021, it revealed the status of awareness and acceptance of the Covid-19 vaccination to the Rohingya community during that period. The quantitative survey found that more than 55% of respondents (n= 1028) had not heard about the Covid-19 vaccine during the time of our data collection. Only 49.7% males (n-=222) and 38.9% female (n=805) respondents had heard about the Covid-19 vaccine, mostly from their neighbors, relatives, and friends. Male respondents reported having Covid-19 vaccine information mostly from their social networks and media (TV and radio), whereas female respondents reported learning about Covid-19 vaccine mostly from community health workers visiting home, miking announcements inside the camps and schools. Out of the 1028 surveyed households, more than 95% of Rohingya respondents expressed interest in the Covid-19 vaccine.

> **"I am not sure where to get this vaccine from? I have heard about it but I do not know how it can save me from the disease (COVID-19)?"** (69 years old male, Unemployed).

However, the qualitative findings show that misinformation and rumors against the vaccine were rampant which were more based on their understandings of 'religion', rather than facts. The most common rumor was that the vaccine was made in the United States of America with 'Shukorer rokto' (pigs' blood), which is 'haram' (prohibited) for Muslims. It is unclear what role local religious leaders played in these understandings and whether mistrust of being refugees in a foreign country had a role in these fears. For most, the logic for the need for a vaccine was also unclear. The issue of concern here is that these rumors were cited mostly by adult male respondents who are the key decision-makers in the patriarchal Rohingya culture, and thus their beliefs could affect entire households' decisions of taking vaccines. Female participants were found more willing to take the vaccine, however, they perceived Covid-19 vaccine as a part of the routine child immunization programs. Therefore, most of the adult female participants were more receptive to the vaccine since they were worried about their children's health and that is a major driver behind their willingness to get vaccinated.

However, they would not be able to make this decision independently as they will require to get permission from their husbands or male household heads.

Apart from that, there was a misconception prevailing in the community that only those who have been infected with COVID-19 should get the vaccine which is impacting some people's decision to avail the vaccine. Likewise, some other respondents believed that this vaccine contains some side effects that also spread doubts about this vaccine.

> **"Why should I take the vaccine when I am completely fine (free of any disease)?"** (30 years old male, day laborer)

> **"We would take this vaccine only if we are confirmed about our safety. What if we die because of this vaccine?"** (22 years old male, Small business owner).

Community's perspectives on Covid-19 information dissemination

Main sources of information: The three most reported primary sources of Covid-19 information reported by the survey respondents were miking in the camps (41%), NGOs/INGOs (33%) and friends/relatives (19%). However, to the men NGOs/INGOs were the main sources of information as reported by 32% of male respondents, while 44% of female respondents identified miking from CIC offices as their main source of information.

The qualitative findings revealed that the Rohingya community, across all age and gender groups, considered ''Imam" (Muslim religious leader) as the most trusted person for any information, as religion plays a critical role in their lives.

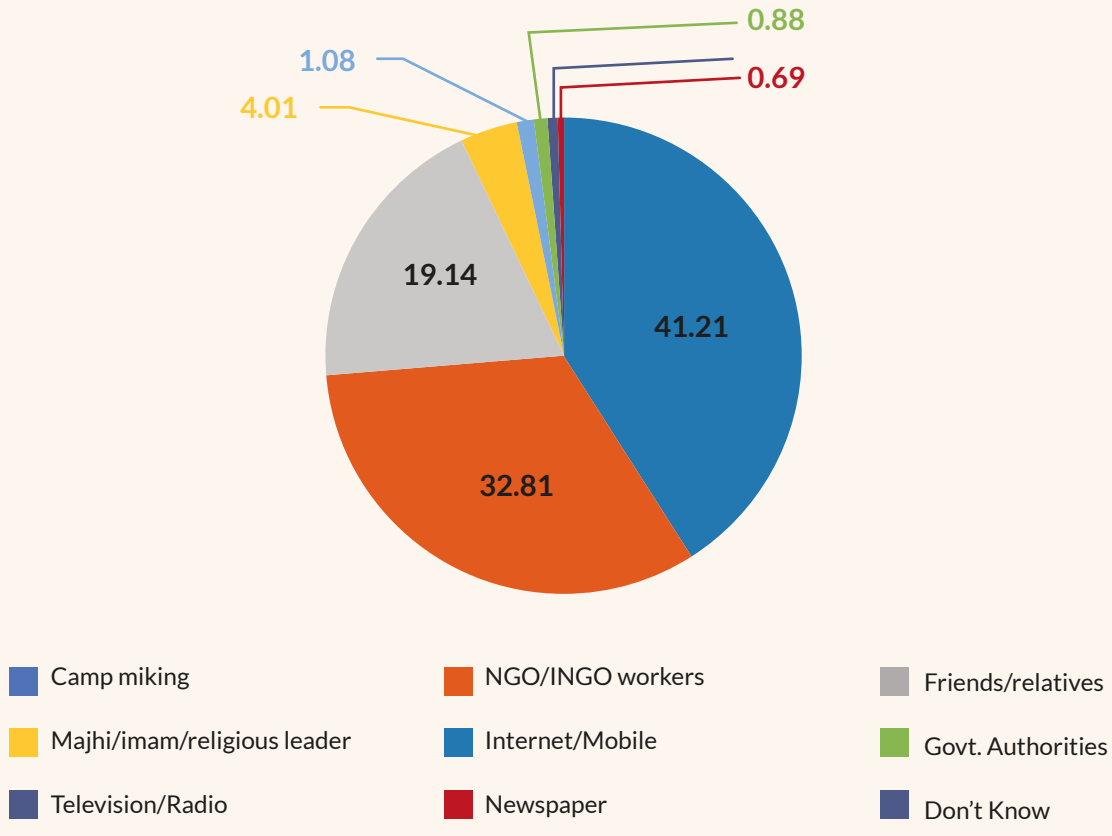


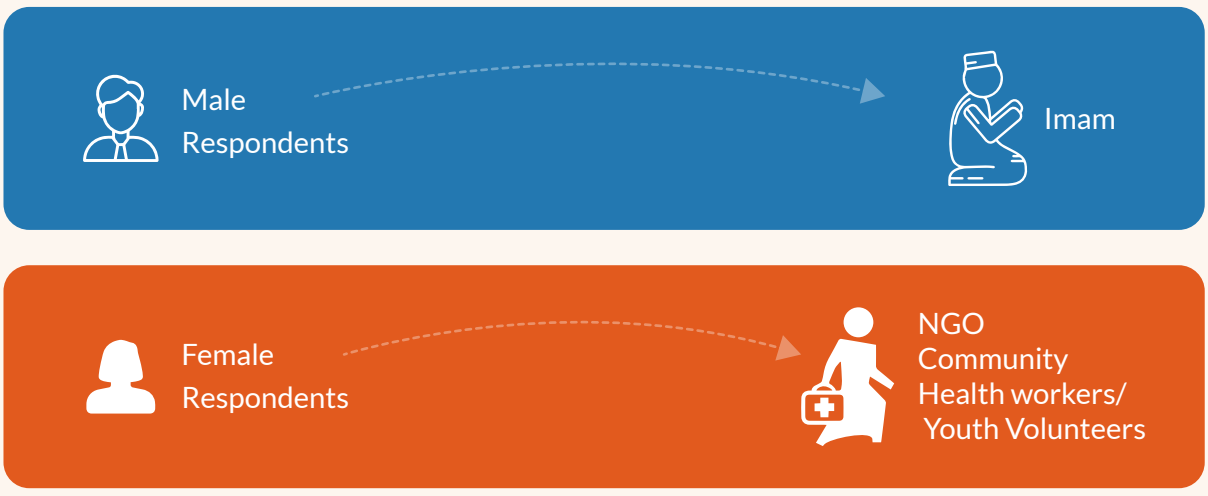
Figure 3: Initial sources of Covid-19 related information of the Rohingya community

All participants, across gender and age groups, emphasized that Covid-19 related announcements should be scheduled according to the needs and working hours of the community residents. They recommended that announcements and information should not be provided on designated ration distribution days, as people remain busy collecting their rations, which is crucial for their daily survival.

> **"If you come to talk to us when we need to go to get rations then we cannot listen. We are busy on those days. So, better not to come on those days."** (27 years old female, Homemaker)

Women's preference: Qualitative data shows that Rohingya female participants emphasized on the miking done by CIC offices as an effective channel of disseminating Covid-19 information as it covered a large population and women could easily listen without going out of their homes. They also found door-to-door visits by NGO/INGO female community health workers effective and women-friendly as they could directly learn from females without hesitation and could leverage this opportunity to ask face-to-face questions and learn more accurately. Due to the local gender norm on mobility restrictions for women, most of the female respondents could not attend Covid-19 courtyard sessions and meetings organized by different NGOs. Some of the sessions were male-led where females felt uncomfortable and hesitant to ask questions. Therefore, it is evident that there is a lack of access to information in general for women, and door to door visits bridged this gap and provided access. Since female CHWs are from the same camps and almost always present in the community, members trusted them and relied on their suggestions. Female participants also preferred information disseminated during the morning time, preferably before 10 am as most of them become busy with household chores after that. They also suggested avoiding the five Islamic prayer timings for miking.

Trusted people in the Rohingya community



Men's preference: In the qualitative interviews and group discussions, adult male participants mentioned round table meetings with community members organized by NGO workers to be an effective method of information dissemination as large groups of men could gather at these meetings and could be provided with accurate information. Most of them identified "Golghar" (public meeting places inside the camps) as the preferred and effective place for information dissemination in the community. Male participants also identified community leaders, block committee members and the Camp-in-charge (CIC) as the trusted people who they believed provided them with credible information. For adult males, the most convenient time to communicate with them any information would be any time between post-lunch hours and post afternoon prayers (post 'Zuhr" prayer to 'Asr' prayer i.e., 2:00 PM to 4:00 PM), when they usually return from their work and would be available to meet others and listen.

Adolescents' and youths' preferences: In qualitative assessments, some adolescent and youth male participants cited mobile-based social media platforms as effective methods of information dissemination despite the poor internet connection inside the camps. They believed that people are more likely to remember what they see on social media and remember that information.

> **"When we see videos on WhatsApp, we remember what it said, and we try to follow that."** (17 years old male, Unemployed)

Male adolescents and youths preferred afternoons, specifically after 12 pm, for information dissemination as they return from madrasas/coaching/work at that time and are available to attend dissemination meetings and listen to Covid-19 related announcements. On the other hand, similar to other female participants, female adolescents and youths preferred courtyard sessions and CHWs' home visits because of their mobility restrictions outside the home.

Impact of Covid-19 on Rohingya communities

Economic Impact

To understand the economic impacts of Covid-19 on the Rohingya community, the quantitative survey respondents in 1028 households were asked about their jobs and household income status during pre-pandemic and pandemic (within one month before the data collection) periods. About 68% of 1028 respondents reported no change in their livelihood attributed to the pandemic and lockdown (Figure 4).

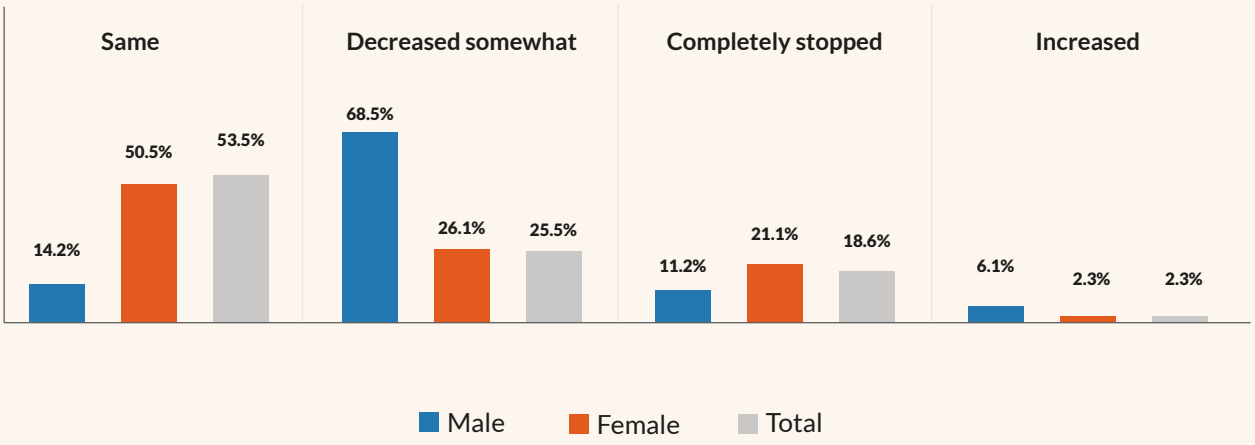


Figure 4: Situation of household income compared to pre-pandemic levels

Regarding household income compared to the pre-pandemic period, over half of the respondents (54%) reported no change, whereas 26% reported a reduction, and 19% reported a complete loss of their income. Among those who reported a reduction or total income loss, about 61% mentioned reducing their expenditure, and 42% reported taking loans from different sources to manage their household expenditures. About 56% of 1028 surveyed households reported getting support from private sources, 31% reported getting government support, and 30% got financial or in-kind support from their extended families/friends /relatives. During the lockdown, only 45% of surveyed households of the Rohingya community reported receiving food in terms of relief support.

In the qualitative interviews, almost all adult and young male respondents shared that they had lost their daily labor jobs due to the lockdown in the camps. However, many of them also admitted to never having a regular job even before the pandemic, as they were primarily dependent on humanitarian aid. As noted by one young male participant,

> **"We used to do small jobs around the camps like masonry, labor, etc., but when they enforced the lockdown, we lost all our jobs"**
> (22 years old male, Day laborer).

Some men also work as informal workers/day laborers inside the camps' construction sites. During the informal discussions with several key stakeholders, there was also an illegal informal trade between the Rohingya and the host communities where men worked as cheap agricultural laborers in the host communities. Such sources of income were hampered and, in most cases, stopped due to the strict lockdown imposed in the camps because of the pandemic.

Impact on food security

Compared to the pre-pandemic period, half of the representatives of the 1028 surveyed households in the quantitative survey reported a decline in the food consumption levels (Figure 5).

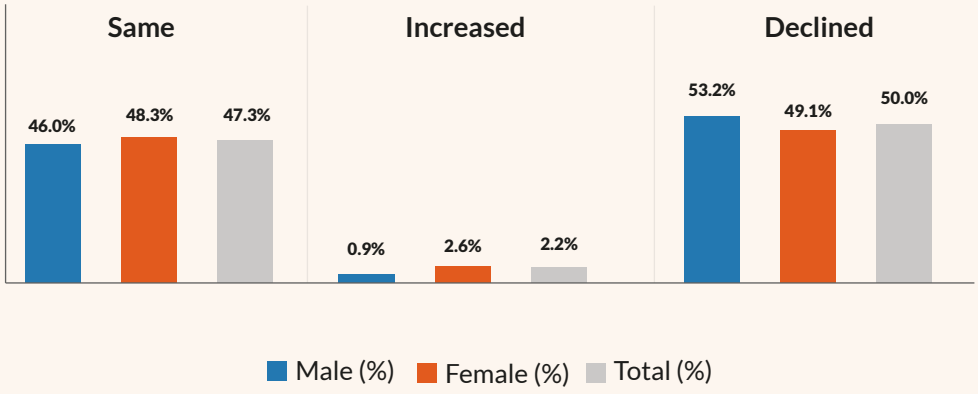


Figure 5: Self-reported food consumption levels compared to pre-pandemic levels

Most of the respondents also mentioned that during the nine months of the pandemic in Bangladesh (April – December 2020), their families had to skip meals for an average of 26 days, and around half (51%) of the 1028 surveyed households mentioned that they could manage only rice on an average 1-3 times in a month. Overall, 65% of surveyed households reported running out of food due to financial constraints in the past nine months of data collection.

To deal with food shortage (Figure 6), amongst 1028, about 70% of the surveyed households reported borrowing food, 66% eating less food than their requirement, and 56% borrowed money to buy food. Only 8.5% of 1028 surveyed households reported having food stocked in their houses.

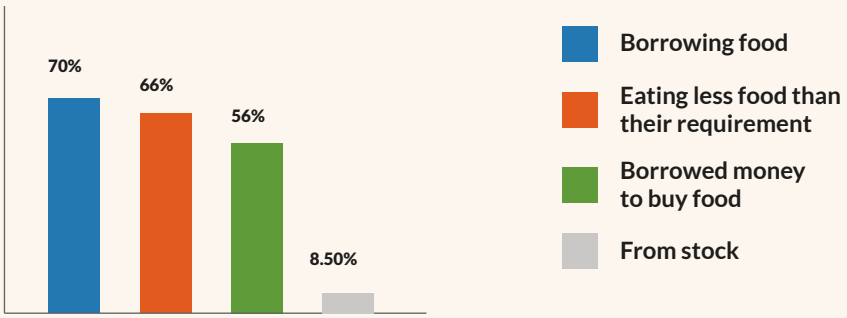


Figure 6: Coping mechanism with food shortages during Covid-19

In the qualitative assessments, almost all groups of participants mentioned that although they mostly received food (mostly dry food– rice, lentils, cooking oils, etc.) and some commodities (e.g., soaps, detergent etc.) as rations from humanitarian aid agencies, they were reportedly insufficient in quantity to meet the household needs or their daily necessities. Reportedly, the food ratio was provided every month to each family, and the balance size depended on the number of family members. However, the amount and number of items in the ration had been reduced during the lockdown. The families and persons who were solely dependent on allocation suffered massively. During the lockdown, they did not receive adequate food to suffice for the entire family. Most women respondents mentioned compromising their food portions to feed their children and husbands. Most of the adult female respondents mentioned that, the quality of the food rations was also not good and often they received rotten food. also One adult female participant said,

> **"We got rotten fish and potatoes. How can we eat that? Sometimes they did not give us onions. And the rice was not enough for the whole family. Then how can we eat properly?"** (30 years old, Homemaker).

Social Impact

In the household survey (n=1028), the most-reported social impacts of the Covid-19 lockdown ware – not being able to go to mosque/temple/church for regular prayers (92%), inability to host/attend marriage ceremonies (91%), not being able to meet neighbors/relatives/friends (89%), and not being able to socialize at the marketplaces (81%).

The participants of qualitative assessments, across all age groups, also mentioned that the most significant social impact of Covid-19 was the banning of public gatherings, including socialization at marketplaces/local tea stalls, not being able to arrange/attend "Waz mehfils" *(a Muslim religious gathering where a large group of people gather to listen to speeches of locally renowned Muslim scholars and perform prayers together)* and closure of mosques.

Since social life for many in the Rohingya community is driven by their religious beliefs, the complete shutdown of these activities disrupted their spiritual practices and social relationships. As mentioned by one male participant,

> **"we told them (Government officials and NGO workers) that we need to go to the mosque to pray, even if we die. Then, they told us to maintain physical distancing during prayers"** (28 years old male with a physical disability, small business owner).

Reportedly, the complete shutdown affected older adults, women without male family members, and PWDs primarily. They relied on the social custom of assisting each other with collecting rations and relief materials. Due to people's movement restrictions and instructions to stay at home during the lockdown, these groups suffered as no one could help them get their rations.

Impact on non-Covid-19 health-seeking behaviour

Around 75% of respondents out of 1028 surveyed households reported at least one ill person in the household over 15 days preceding the interview in January 2021. The first point of contact for seeking healthcare was reported to be local drug shops/pharmacies (37%), Burmese Doctors (31%), and certified public or private medical doctors (22%).

During the qualitative data collection in the Rohingya community, the female participants mentioned that the health facilities were closed during the lockdown and they could not access essential medicines when needed. One pregnant mother said that her healthcare workers used to be more supportive before the COVID-19 pandemic, but when she visited them during the pandemic, she could not find the doctor, and the staff showed no signs of compassion towards her own words. As mentioned by one lactating mother,

> **"I had unbearable pain and thought I would die…I wanted the baby out (delivery), but there was no one available in the health center during lockdown"** (28 years old, Lactating mother, Homemaker).

Another barrier was seeking permission from local authorities to leave camps to access services. The female respondent complained that they could not visit hospitals far from the camps as they needed money and permission from the CiC to do so. She shared,

> **"If we could, we would go outside to Ukhiya and Cox's Bazar to see the doctors there. But we cannot. So, we have to go to these people (doctors in the camps), but we do not want to. They do not listen to us. So, what is the point of going there?"** (27 years old female, Homemaker).

Covid-19 impact on Mental Health

In the household survey (n=1028), around 41% of respondents reported having trouble sleeping at a frequency of several days, 39% reported feeling depressed and difficulty concentrating on things like reading the newspaper or watching TV (29%).

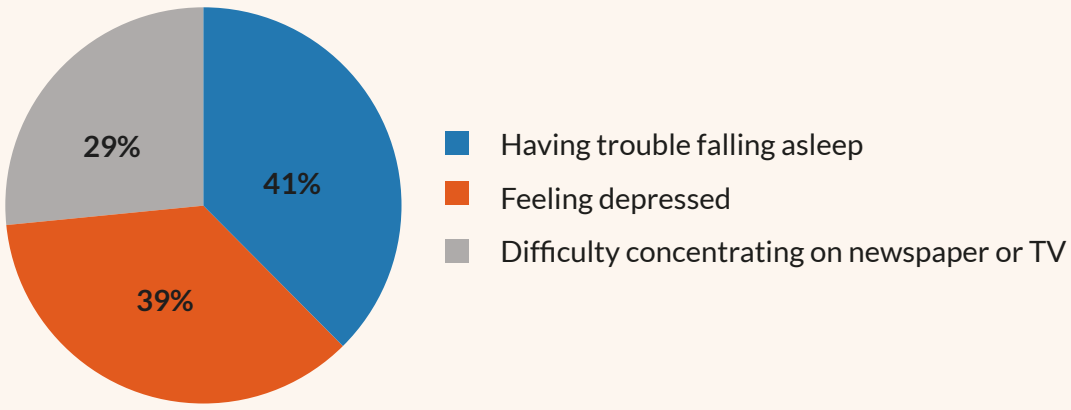


Figure 7: Mental Health Impact on respondents

Our qualitative findings showed that limited work opportunities made the adult and adolescent boys anxious and stressed. The adult females echoed similar anxieties and cited food insecurity as one of their biggest fears. Most female participants emphasized their worries that inadequate food would affect their children's health. Moreover, few younger women and adolescents mentioned having worries and anxieties about this disease. The fear of being infected with this virus and the risk of the infection of their families impacted their emotional state and wellbeing.

Impact of Covid-19 on Most Vulnerable Groups

Impact on single-female-headed households

The research found single female-headed households were more vulnerable among the most vulnerable groups. The gender vulnerability index revealed that the intensity of vulnerability is comparatively very high in female-headed households. More than one-fifth of the female-headed households (n=327) who participated in the household survey reported a complete stop of household income during the lockdown in 2020. More than half of the respondents (n=327) reported that their food consumption declined during the lockdown compared to the pre-pandemic situation. Almost 80% of these vulnerable households could not stock up food for the crisis period mainly due to lack of money and thus reported that they could survive an average of 9 days with the amount of food they had during the data collection period.

The qualitative data found that females had limited access to income-generating activities because of the social and gender norms. Due to the absence of a male person in the house, many of them felt socially excluded and invisible than the other families with male members. This was complicated because there were insufficient income sources in the camps, particularly for females. The case studies also highlighted that most single female-headed households depended on the provided rations (humanitarian aid). Most of them mentioned seeking help from their neighbors regarding ration collection. As noted by one single mother,

> **"I do not have any male person in the house. I have to seek help from my neighbors every time during ration collection. Sometimes it is very embarrassing for me. If I had a male person in my own house, I would not have to beg like this"** (22 years old, Pregnant Mother, Unemployed).

Impact on Pregnant or Lactating Mothers

Among 347 pregnant and lactating mothers participated in the household survey, 63% reported delivering their last child at home and 30% delivered at NGO hospitals.

The qualitative findings show that even though many health facilities were open during the lockdown, women were uncomfortable or unwilling to visit health facilities during pregnancy due to the fear of COVID-19. Many other pregnant mothers shared that they were not treated the same way by the healthcare providers as they used to be treated before the pandemic. For instance, many participants mentioned that the doctors did not perform any physical check-ups in the health facilities but rather maintained a distance from them due to fear of COVID-19. This made many pregnant and lactating women upset. As mentioned by one pregnant mother,

> **"there were some hospitals open, but I did not feel comfortable going there because the staff (health personnel) do not check thoroughly. They will stay far away from the patient and give everyone more or less the same medicines".** (22 years old, Pregnant Mother, Unemployed)."

Impact on Adolescents

The COVID-19 impact on adolescents was visible from the household survey, especially in education, with 72% of 382 interviewed adolescent boys and girls reported a stop in education. Roughly 1% of 382 reported continuing education online, while around 6% reported going to Madrasas (religious education) in the camps. Regarding safety and security, a large portion of adolescents (45% of 382) said that they felt 'very safe' going out at night, whereas 34% reported feeling 'somewhat unsafe,'' with slight differences between male and female adolescents. Regarding reasons for not feeling safe, 72% of 193 male adolescents feared being mugged or physically attacked, with a significant difference between males and females.

The qualitative findings found that most of the adolescent participants across gender mentioned the lack of food availability due to ration reduction during the initial phase of COVID-19 movement restrictions in the camps. As a result, many adolescent girls mentioned eating less or skipping meals to provide for the other family members. In the words of one adolescent girl,

> **"They provided less ration throughout the lockdown. Therefore, we were eating less… Sometimes we ate rice only with salt… We were struggling to eat two times during the whole lockdown"**
> (15 years old, Adolescent girl, Unemployed).

Some male adolescents also expressed their fears that they were at greater risk of contracting the virus since each household was close. As mentioned by one adolescent boy,

> **"I do not understand how we can maintain distance in these camps. We are living so close to each other. I think ultimately every one of us will contract the disease (Covid-19)" (16 years old, Adolescent boy, Day Laborer).** (22 years old, Pregnant Mother, Unemployed)."

Impact on the Elderly people

Around 84% of 212 elderly people (65+ years of age) interviewed in the household survey received some special care provided by the government or NGOs in Rohingya camps. The most pressing concerns among most of them (Figure 8) were availing transport (76%), personal finances (56%), physical health (45%), and mental health (39%). Overall, less than 50% of them believed that the pandemic had created problems in their daily lives, mostly in terms of difficulty in seeking healthcare services.

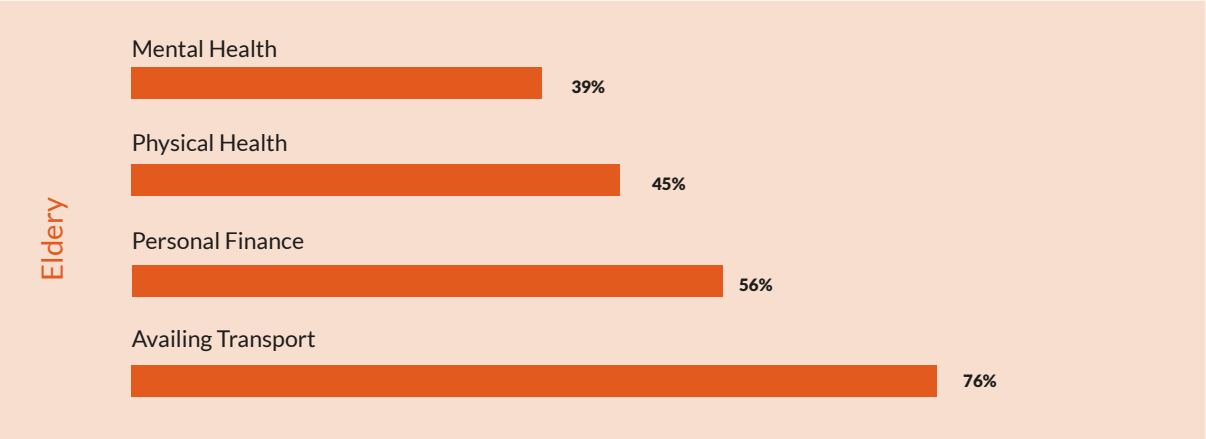


Figure 8: Concerns about daily life reported by elderly respondents

The qualitative data found a lack of knowledge regarding COVID-19 disease, especially among older women. Most of the elderly participants were found unwilling to maintain safety measures as they did not understand the seriousness of the pandemic. In the words of one older adult,

> **"I do not believe in this Corona. My son and daughter-in-law just want to cage me in the room. They do not want to take care of me as I need help when I move from one place to another, and they do not want to help me. That is why!"** (68 years old woman).

Impact on Persons with Disabilities

In the household survey, the majority (55%) of the 247 persons with disabilities (PWDs) interviewed reported having difficulty in mobility because of not being able to avail transports. The PWDs were most concerned about personal finances (59%), physical health (54%), and their families' wellbeing (38%).

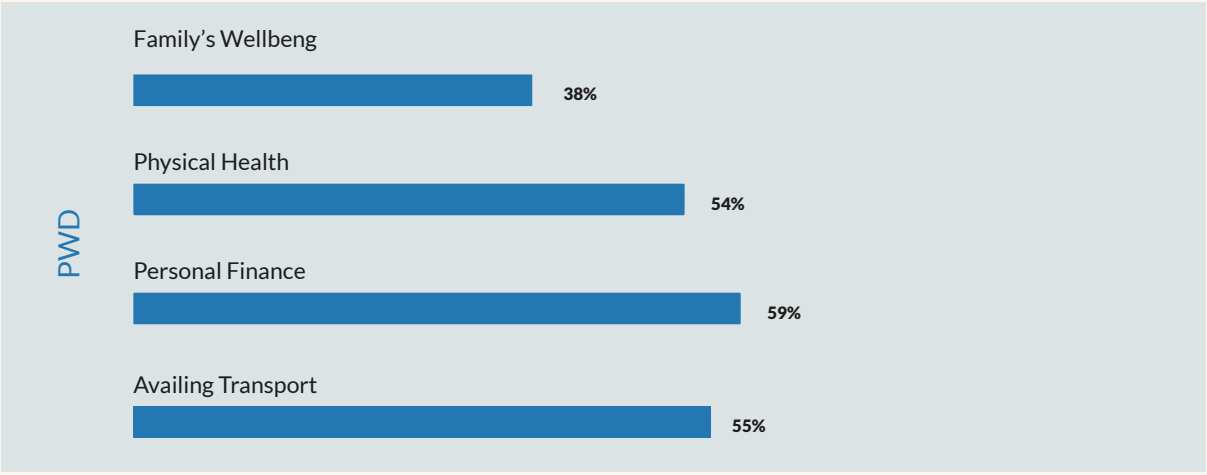


Figure 8: Concerns about daily life reported by PWD respondents

In the qualitative interviews, most PWDs reported mental health concerns due to the pandemic. They were worried about contracting the disease, which may burden their families. However, some of the PWD participants mentioned that they did not struggle as much to avail health services as services were available in multiple health facilities. Additionally, they mentioned that many NGOs were working hard to ensure health service delivery since the beginning of the pandemic. In contrary, some PWD participants shared that they faced difficulty in collecting rations as they could not get assistance from others due to the movement restriction in the camps.

> **"Before, others would help me bring my rations. But now everyone wants to stay away because of fear of the virus and just do their work. No one helps me anymore, so I have to struggle"**
> (65 years old male, Unemployed).

Conclusion

This report identifies MVGs in the Rohingya community of 'Cox's Bazar in the context of Covid-19 - pregnant and lactating mothers, adolescent boys and girls, single female household heads, PWDs, and the elderly. The drivers of their vulnerabilities are intersectional and represent deeply embedded gender, social, cultural norms, and the catastrophic economic impact of Covid-19 (9-10). Moreover, multiple MVGs in a household further increase their vulnerabilities. The findings also suggest that the community people have many misconceptions about Covid-19 that require targeted interventions. There are significant economic, social, and health impacts on the people, exacerbated by their pre-existing vulnerabilities. Together, these factors exhibit severe effects on these groups, making them complex populations requiring special attention from implementers and policymakers.

Recommendations

The study suggests the following policy recommendations.

1. Clear messaging for Covid-19 risk communication:
Culturally appropriate, accurate, and precise messaging is required to address the social, religious, and other concerns regarding Covid-19. Community gatekeepers (like Imams, CHWs, etc.,) need to be included in the campaign as they are the most trusted people in the community. Moreover, culturally contextualized explanations in simple local language with pictorials and video demonstrations are required.

2. Risk communication on social media to reach the younger generation:
In the current context, social media platforms could be leveraged to target young adults and adolescents as the penetration of digital tools is deeper in these age groups.

3. Targeted approaches for MVG:
For the MVGs, it is important to establish priority lanes and shorter waiting areas at health centers/facilities. Additionally, special food and cash assistance to households/families with members from MVGs are recommended.

References

1. UNOCHA. (2019). Rohingya Refugee Crisis. UNOCHA. https://www.unocha.org/rohingya-refugee-crisis

2. Rahman S, Ahmed O, Hasan R, Yeahyea H binth, Azam SW, Hossain Zihan. Covid-19's Impact on Host communities across Cox's Bazar. Cox's Bazar (2020). https://www.inspirabd.com/covid-19-retrospect-covid-19s-impact-on-host-communities-across-coxs-bazar/ [Accessed July 1, 2021]

3. Khaled, A. F. M. (2021). Do No Harm in refugee humanitarian aid: the case of the Rohingya humanitarian response. Journal of International Humanitarian Action, 6(1), 1–13. https://doi.org/10.1186/s41018- 021-00093-9

4. Intersectoral Coordination Group Secretariat. Joint Response Plan for the Rohingya Humanitarian Crisis [Internet]. Cox's Bazar; 2021 [cited 2021 Sep 26]. Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/2021_jrp_with_annexes.pdf

5. International Development Research Centre. Bridging Communities in Cox's Bazar: Mitigating Risks and Promoting Gender, Governance, and Localization of Humanitarian Responses in the COVID-19 Era [Internet]. COVID-19 Responses for Equity (CORE). [cited 2021 Sep 30]. Available from: https://c19re.org/project/bridging-communities-in-coxs-bazar-mitigating-risks-and-promoting-gender-governance-and-localization-of-humanitarian-responses-in-the-covid-19-era/

6. Yasmin L, Akther S. The locals and the Rohingyas: Trapped with an uncertain future: https://doi.org/101177/2057891119865021 [Internet]. 2019 Sep 10 [cited 2021 Dec 13];5(2):104–20. Available from: https://journals.sagepub.com/doi/10.1177/2057891119865021

7. Guglielmi S, Seager J, Mitu K, Baird S, Jones N. "People will not die due to the disease; they will die due to hunger": Exploring the impacts of covid-19 on Rohingya and Bangladeshi adolescents in Cox's Bazar [Internet]. Cox's Bazar; 2020 Aug [cited 2021 December 19]. Available from: https://www.gage.odi.org/wp-content/uploads/2020/08/Exploring-the-impacts-of-covid-19-on-Rohingya-and-Bangladeshi-adolescents-in-Cox%E2%80%99s-Bazar.pdf

8. BRAC JPGSPH. Institutional Review Board [Internet]. BRAC James P Grant School of Public Health, BRAC University. 2021 [cited 2021 Dec 20]. Available from: https://bracjpgsph.org/research-irb.php

9. ISCG. Multi-Sector Needs Assessment: Teknaf and Ukhiya Upazilas [Internet]. Cox's Bazar; 2019 Mar [cited 2021 July 1]. Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/iscg_sitrep_may2019_final.pdf

10. ISCG Gender Hub, ACAPS, NPM Analysis Hub, Care Bangladesh, Oxfam International, UN Women. In the Shadows of the Pandemic: The Gendered Impact of Covid-19 on Rohingya and Host Communities [Internet]. Cox's Bazar; 2020 Oct [cited 2021 Sep 26]. Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/in_the_shadows_of_the_pandemic_gendered_impact_of_covid19_on_rohingya_and_host_communities_october2020.pdf

Acknowledgments

We are grateful to our project partner - Centre for Peace and Justice, BRAC University, for providing us access to their field office in Ukhiya, where all the debriefings were done during the data collection period. They also assisted in the initial research-tool designing with key stakeholders and communities from the Rohingya camps and host communities. We are indebted to the International Development Research Centre (IDRC), Canada, for funding this project. The research team would like to thank all the respondents involved for sparing their valuable time. We are grateful to thank the Refugee, Relief and Repatriation Office, Cox's Bazar and the Camp In-charges for their support during the data collection. The BRAC JPGSPH research team has also benefited from the support provided by the Rohingya response sectors, Cox's Bazar and BRAC Humanitarian Crisis Management Programme, Cox's Bazar during the data collection period.

PHOTOGRAPH BY WILLIAM DANIELS, NAT GEO IMAGE COLLECTION

Funded by:

IDRC · CRDI
International Development Research Centre
Centre de recherches pour le développement international

Canada

The Center of Excellence for Gender, Sexual and Reproductive Health and Rights
BRAC James P Grant School of Public Health, BRAC University
6th Floor, Medona Tower, 28 Mohakhali Commercial Area,
Bir Uttom A K Khandakar Road, Mohakhali, Dåhaka-1213, Bangladesh
Telephone: +880-2-9827501-4
Email: jpgsph@bracu.ac.bd www.bracjpgsph.org

For any queries please reach out to:

bachera.aktar@bracu.ac.bd | sabina@bracu.ac.bd