Understanding the Impact Of COVID-19 Among Most Vulnerable Groups in Rohingya and Host Communities in Cox's Bazar, Bangladesh

Summary Research Findings

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Background

The Covid-19 pandemic and its subsequent protocols have greatly affected all populations worldwide, particularly the most vulnerable groups (MVGs) living in fragile contexts like humanitarian settings. Bangladesh hosts the largest refugee population in the world - Forcibly Displayed Myanmar Nationals (FDMN), commonly known as Rohingyas. Around 860,000 Rohingyas currently reside in 34 densely populated camps in Ukhiya and Teknaf sub-districts of Cox's Bazar district in Bangladesh, (UNOCHA, 2019; World Vision, 2020). They are surrounded by around half a million Bangladeshi host population (UNDP, 2018) who are one of the poorest population groups in the country with a poverty rate of approximately 32% (Relief web, 2018). Since the arrival of the largest influx of the Rohingya population in August 2017, Rohingyas and the adjacent host communities have been experiencing new challenges in diverse areas of daily life such as social, financial, food security, education, general health services, etc. The Covid-19 and the accompanying containment measures significantly impacted women, girls, boys, people with disabilities, and other marginalized groups across all camps and the host communities.

BRAC James P Grant School of Public Health (JPGSPH), BRAC University conducted a participatory action research project in partnership with the Centre for Peace and Justice (CPJ), BRAC University from August 2020 to July 2021 among Rohingya and host communities in Cox's Bazar Bangladesh with an aim to provide critical evidence to influence policies and interventions, using gender-transformative approaches, to minimize the adverse impact of COVID-19 among the most vulnerable groups in Rohingya camps and the host community. The project was funded by International Development Research Centre (IDRC), Canada. The overarching objective of the research was to identify MVGs in both Rohingya camps and the host community and new forms of gendered vulnerabilities, and to understand the impacts of COVID-19 on MVGs in both communities. The research also explored COVID-19 related knowledge, perceptions and practices of both Rohingya and host communities as well as their reflections on the existing COVID-19 responses by the humanitarian actors.

JPGSPH was the lead partner and conducted the research. The implementation partner CPJ utilized the research evidence to develop contextually relevant messaging and tools on COVID-19 awareness and trained a network of Youth Volunteers and camp-based organizations who organized and facilitated community-based awareness workshops within the communities.

This summary report presents key findings of the research. To separate research briefs are produced for the Rohingya and the host communities with more details of methodology and findings.

Methodology

This research was conducted in 10 selected Rohingya camps and four wards in the surrounding host communities of Rajapalong union in Ukhiya sub-district of Cox's Bazar. A mixed-method research design was applied whereby a formative qualitative research was conducted followed by a household survey and further qualitative assessments of MVGs identified with the help of the literature and expert opinions in a research design workshop.

The qualitative party of the research included a total of 111 in-depth interviews (58 with Rohingyas and 52 in host community), 11 key informant interviews (6 in Rohingya and 5 in host community), 17 case studies (12 in Rohingya and 5 in host community) and 35 focus group discussions (19 in Rohingya and 16 in host community). A total of 2,063 households (1028 in Rohingya and 1036 in host community) with at least one member from MVGs were interviewed in the household survey.

Key results

Identification of the most vulnerable groups

This research identified the following five groups as the most vulnerable in both Rohingya and the host communities.

Most Vulnerable Groups (MVGs)	Description
Pregnant and Lactating Mothers	Currently pregnant or lactating mother with a child < 2 years
Adolescents	Both boys and girls with age 10-19 years
People with Disabilities (PWDs)	Person with any type of disability and age 18+ years
Single female headed HH without income/low income	Women who are widow/divorced/abandoned by spouse
Elderly people	Both male and female of age 64+ years

Perceptions regarding causes, consequences, and modes of transmission of COVID-19

The primary cause of COVID-19 was reported to be religious in both communities owing to the conservative religious views existing in both Rohingya and host communities. However, the Rohingya community appeared less afraid of the disease than the host. The Rohingya community people believed that COVID-19 would only cause death for them if God wanted it to happen and were somewhat 'fatalistic' in their attitudes. However, the host community feared the consequences of COVID-19 to be death itself, which caused fear and panic amongst them. Respondents in both communities were able to identify modes of transmission such as coughing, sneezing, and touching. However, there was still a lack of correct and accurate information, which led to a lack of practice of safety measures.

Observations of the practice of safety measures and misinformation impacting practices

The researchers observed a clear gap between knowledge of safety measures among the community and compliance with those measures. Many different reasons were reported for the lack of compliance including religious beliefs, fewer reported cases of COVID-19 in both communities, the absence of deaths, and the lack of adequate hygiene supplies.

Effective methods of information dissemination

The preferred methods of information dissemination differ between men and women in both communities. Women prefer ways to provide them with first-hand information at their homes from trusted sources such as community health workers. On the other hand, men prefer to receive information from religious or community leaders outside their homes. This could be due to the different aspects of mobility among men and women, with women being much more confined to their homes.

COVID-19 Vaccination

The primary data showed a gap in knowledge regarding the COVID-19 vaccine in both communities. Most respondents had not heard about a vaccine at the study time. However, when asked about a COVID-19 vaccine, they were willing to avail the vaccine, given the male household heads permitted everyone to avail of it. There were some concerns regarding vaccine rollout, particularly in the host community,

regarding whether they or Rohingya communities would be prioritized during the rollout, and misinformation regarding the high costs of accessing these vaccines. Currently, the national level vaccine rollout in the country is free. Additionally, there was religious propaganda against the vaccine in both communities. This was reported mainly by adult males who are household heads and decision-makers for the rest of their household members, including their spouses.

Impacts of COVID-19

***Social impact*:** The COVID-19 induced lockdown affected regular social activities such as religious gatherings and marriages in both communities. This resulted in a loss of social networks for the community, which negatively impacted their psycho-social and mental well-being.

***Economic impact*:** One of the greatest impacts of COVID-19 was the loss of earning sources, especially for the already economically vulnerable. This had far-reaching consequences, especially on people's food security and food consumption which was greatly affected. However, in this regard, the Rohingya community suffered less than the host community as they regularly received rations and relief from the government and humanitarian agencies. Most affected were female-headed households.

Impact on food security: The economic impact of COVID-19 also impacted the food security situation in both communities. Respondents from both communities reported a loss in food consumption and an inability to stock food for the future due to a lack of money.

Impact on general health-seeking behavior: Due to the COVID-19 induced lockdown, there were issues with affordability and accessibility of health services in both communities, poor quality of care, and bad behavior by providers and doctors. This led to a brewing mistrust of formal health care providers in the community. Many respondents seemed to prefer informal health care providers.

***Impact on mental health*:** In both communities, respondents reported increased mental stress, anxiety, and depression due to the fear of COVID-19, the complete lockdown, and financial hardships that people were facing due to social restrictions and small jobs, businesses, and labor being adversely affected.

Impact of COVID-19 on the MVGs

Pregnant and lactating women: During the lockdown period, home deliveries increased compared to deliveries in hospitals in both communities. This was due to both socio-cultural norms and barriers in the health systems. In the Rohingya community, Women primarily prefer home births, and for both communities, there were inadequate services available during this period.

Adolescents: The stoppage in education was the most significant impact on the lives of adolescents during the lockdown. However, the effect was disproportionately felt in the host community and led to a loss of mobility, social networks, and an increased risk of early marriage in the case of adolescent girls.

Elderly: In the Rohingya community, the elderly face challenges in seeking health services, and in the host community, the elderly reported adverse mental health impacts stemming from worries about the pandemic and its impact on their lives.

People with disabilities (PWDs): In the Rohingya community, the PWDs reported feelings of inadequacy and feeling like a burden on their families in an ongoing crisis. While in the host community, PWD Respondents reported health care access issues to be the immediate impact of COVID-19.

Single female household heads: The immediate impact of COVID-19 on single female household heads were mostly economic. These women did not work or in very low-paying jobs in the host communities. As a result, there was a loss of income and consequent food security issues during the lockdown. They seem to be the worst affected in host communities, whereas Rohingyas received rations. Still, reduced amounts being distributed during the pandemic impacted their food consumption.

Gender-based vulnerability index

We derived an index, a numerical score of each household derived from a linear combination of indicators that determine vulnerability, to identify and classify the households into different vulnerable groups such as low, medium, and acute. Findings suggest that Rohingya households are relatively more susceptible than the host households. The intensity of vulnerability is comparatively high among female-headed families in both communities compared to the other MVGs groups.

Conclusions

Findings suggest that the community people have some misconceptions about knowledge and practices of COVID-19, which may make them difficult to prevent the disease. There are significant economic, social, and health impacts on the people of both communities, which are exacerbated by their pre-existing vulnerabilities. Considering the misconception of COVID-19 disease and its subsequent effects, the national and international agencies working for the well-being of such vulnerable people can make adequate plans and policies to address this and reduce the pandemic burden to some extent.

Recommendations to inform policy and practice

Recommendations for the Health sector partners (national and international NGOs)

1. **Clear messaging for COVID-19 risk communication for both Rohingya and the host communities**:
    - **a.** Culturally appropriate messaging to address social, religious and other concerns regarding COVID-19 is required for both Rohingya and the host communities.
    - **b.** Accurate and clear information on the importance and need to maintain protection and prevention guidelines, reinforced by local leaders, imams, and youth ambassadors would be beneficial for the retention of information and encouraging both Rohingya and the host community people. For example, local trusted persons as identified by the Rohingya community (religious leaders/Imams, community leaders, CiCs and CHWs) will facilitate behavioral changes. Similarly, the host community identified Imams, 'Khatib', Upazilla Nirbahi Officers, and local Union Parishad members and Chairman and CHWs as trusted persons. These actors need to be sensitized and involved in communication messaging.
    - **c.** In addition to disseminating correct information, it is equally important to provide explanations for information provided, for example, in simplified local language with pictorials and video demonstration on signs and symptoms, how to wear masks properly, defining physical distance, etc. including referral numbers for effective uptake of appropriate services. Both Rohingya and the host community people would be benefited from pictorial/video messaging provided in simple local languages.

d. Culturally contextualized explanations in awareness campaigns addressing fears around testing, detection, isolation, quarantine and burial, etc. is very important to ensure timely care is sought.

e. According to the 2021 Joint Response Plan (JRP) for Rohingya Humanitarian Crisis in Bangladesh, the Health Sector and the Government of Bangladesh are committed to provide COVID-19 vaccines to both Rohingyas and the host community people. However, our research found misinformation and rumors around vaccines and lack of vaccine information dissemination which will create challenges for future roll-out in both communities. Therefore, we are recommending including vaccine messaging in COVID-19 awareness program including clear messaging on adult vaccination, importance of taking vaccine, it's free distribution and the process and places of availing vaccines when they become available.

2. **Risk communication on social media**: Social media has a critical role in COVID-19 infodemic and spreading misinformation and rumors. At the same time, this is also an important source of information to the younger generation. The Government of Bangladesh and Health sector partners in Cox's Bazar including UN agencies, international and national NGOs can come forward for developing short learning videos which can be shared in trusted social media pages (for example, RRRC's or BRAC's official Facebook pages). Local youth volunteers, community health workers and CiC offices (for Rohingyas) can be involved in sharing those links among the young people and people who have access to smart phone and internet connection.

3. **Targeted approaches for MVGs**: Targeted approaches should be taken for MVGs, especially female headed households, women, pregnant mothers, adolescents, elderly people and PWDs in both Rohingya and the host communities. These groups are more vulnerable due to many factors - social, economic, physical, gender, age and other barriers which result in them being left out or being left behind. We propose the following:
    a. Specific approaches are required to ensure they receive COVID-19 messaging as highlighted in the research findings.
    b. Priority lanes and shorter waiting areas for this group when they are visiting health care centers/facilities. Agencies/stakeholders responsible for food distributions among FDMNs should review food rations (quantity and quality) for female HHs, who suffered the most.
    c. NGOs should come forward with special food and cash assistance to households/families with members from MVGs in the host community, especially for those who lost their income sources due to the pandemic or unable to go to union parishad for collecting government support.

Recommendations for the Government of Bangladesh and donors

1. We recommend MVGs in both Rohingya and the host communities receive both food and cash assistance. More resource allocation for providing cash support PWDs, female headed households and elderly people.

2. Investment is required for creating sustainable livelihood opportunities for the host community people involved in informal economy sectors, for example, vocational training and cash support or interest free loans for women, female headed households, PWDs, elderly and young adults and other marginalized people. It is important to note, some better off households had been adversely affected by the pandemic and initiatives and financial support will be required for this new emerging economically affected groups.

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