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Research Note

Covid-19 and Rohingya Refugee Camps in Bangladesh

AKM Ahsan Ullah*

Mallik Akram Hossain**

Diotima Chattoraj***

Introduction

Can Rohingya refugees in the camps maintain, despite their best intentions, social or physical distance—the best way, so far, to slow the spread of coronavirus? A severe hurricane suddenly joggled the planet. We slept in one world and woke up in another. The Coronavirus made us believe that great wars do not need great causes. As if we are fighting the fire. Various contagious diseases claimed millions of lives throughout human history (Ghendon, 1994). The stateless, migrants, displaced and persecuted in their own countries are the most vulnerable ones to these diseases. About 50 million people globally died of influenza pandemic during 1918-1919 (Burnet & Clark, 1942). Spanish flu alone killed

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more than 260,000 people in 1918-1919 (Taubenberger et al, 2005). Most deaths from infectious diseases used to occur in developing countries - the countries with the least money to spend on health care (WHO, 1999). However, Corona virus this time has reversed the trend. Originated from the Chinese province Guangdong in November 2002, after an interval, infectious disease like severe acute respiratory syndrome (SARS) in the 21st century appeared over 29 countries (Siu & Wong, 2004). China, Hong Kong, Taiwan and Singapore were the hardest hit. Although, the impact of SARS was short-lived, it affected various sectors of economy in the affected countries. Highly infectious Covid-19—originated in Wuhan, China—has spread in 210 countries very fast, affected, as of now, more than 7.3 million and more than 1,638,339 died. While vaccines are being administered, World Health Organization's (WHO) recommendations for staying in quarantine, isolation, maintaining social distance, and lockdown are only measures available to combat Covid-19 at the moment.

These measures are of course so far seem to be most effective to deter or/and slow the spread of the virus. However, the challenge of maintaining social distance for those living in densely populated areas is insurmountable. Millions of workers whose survival is dependent on the daily labour in informal sectors have been placed in a deep predicament whether to go out risking infection or to die of hunger in confinement. The reality for those living in camps (migrants, refugees, displaced and stateless people) and slums are even more telling. They are destined living in a crowded and tiny space in protracted conditions. Rohingya refugees in Bangladesh are no exception. Bangladesh hosts more than a million of Rohingyas (UNHCR, 2020; Ullah, 2011; 2016; Ullah & Chatteraj, 2018) who were forced out of Myanmar in the face of brutal persecution, rapes and killings (Parnini et al, 2013; Ullah, 2011a).

Rohingya camps in Bangladesh—the largest refugee camp in the world today— could become the hotpots of Covid-19 due to the propinquity of camp settlements. Rohingya camps are overcrowded as many families have more than 10 family members living in one room. More than 100,000 people live in one square mile area. An overwhelming majority is struggling for bringing two meals a day, sanitation (maintaining personal hygiene, washing hand) is a far cry for them. Groceries, kiosks and health centres and schools all are located within the camps making the congestion worse.

The Context

The gruesome brutality perpetrated upon the Rohingya civilians by the Myanmar government since 1942 has driven hundreds of thousands of Rohingyas out of Rakhine district of Myanmar (Ullah, 2011a; 2016; Ullah & Chatteraj, 2018; Maung, 2017; Chen, 2017; Chowdhury, 2017). The Rohingyas are not same as other ordinary people, primarily because they have either experienced or witnessed most heart-wrenching brutal treatment and were denied basic services like health, education, employment and gross human rights violation (Ullah, 2013; Bogic, Njoku, & Priebe, 2015; Ullah & Chatteraj, 2018; Cernea & McDowell, 2000). Periodically, they have faced violence by forces for generations, which have rendered them vulnerable, even before the most recent crisis of Covid-19. Ullah (2014) notes that the lives of refugees are caught in a predicament where safety, rights and identity are grossly threatened. About 1.2 million took refuge in 36 locations in Cox's Bazar (Map. 1), a district of southeast Bangladesh (Ullah & Chatteraj, 2020). The magnitude of influx made it the world's fastest growing refugee crisis and a major humanitarian emergency (Rahman & Islam, 2019).

The Government of Bangladesh (GoB), with support from various agencies and organizations has been working to ensure that the basic needs are met (Loy, 2020). Health needs are still far from expected (Rahman & Islam, 2019) leading them to vulnerability to Covid-19. Fast and easy contagious nature of Covid-19 has swept the entire world in a just few weeks' time (Muniyappa & Gubbi, 2020; Ullah, Nawaz & Chatteraj, 2020). Sensing the pervasiveness of Covid-19, the WHO hit the nail on the head by declaring this as a pandemic in March 2020. Globally the slogan 'Stay Home, Stay Safe' has now been a new way of lifestyle amid Covid-19 crisis (Ullah, Nawaz & Chatteraj, 2020). For the Rohingya refugees 'stay home' policy came as a double-edged sword. The question we ask is how do they manage staying healthy under this circumstance (Health Sector Bulletin, 2019). Due to the limited mobility opportunity for the Rohingya population, they cannot access health services provided by NGOs, INGOs at the time they need it most (IOM, 2020; Truelove et al, 2020).

The world is racing to find an effective vaccine in order to thwart the vigor of the virus. This is of course showing the beacon of hopes against the crisis the world has seen since World War II. Evidently,

the Rohingya population group has been undergoing serious neglect. Without doubt by any reckoning, they, at the moment, are the most vulnerable to COVID-19 due to the congestion of the space they are allocated to live in.

Objectives and methodology

The main objective of the paper is to look into how the Rohingya population in refugee camps in Bangladesh handles the long-term potential health impact of Covid-19. Specifically, the paper pursues the following objectives. This delves into how they handle this situation under a controlled environment in the refugee camps and what could be the gravest consequences of COVID-19 on this population group. Previously, under three projects we conducted a number of studies (Ullah, 2011; 2016; Ullah & Chattoraj, 2018) on the Rohingya population living in the camps in Bangladesh. Given the situation we wanted to know how is the social distance maintained in the camps.

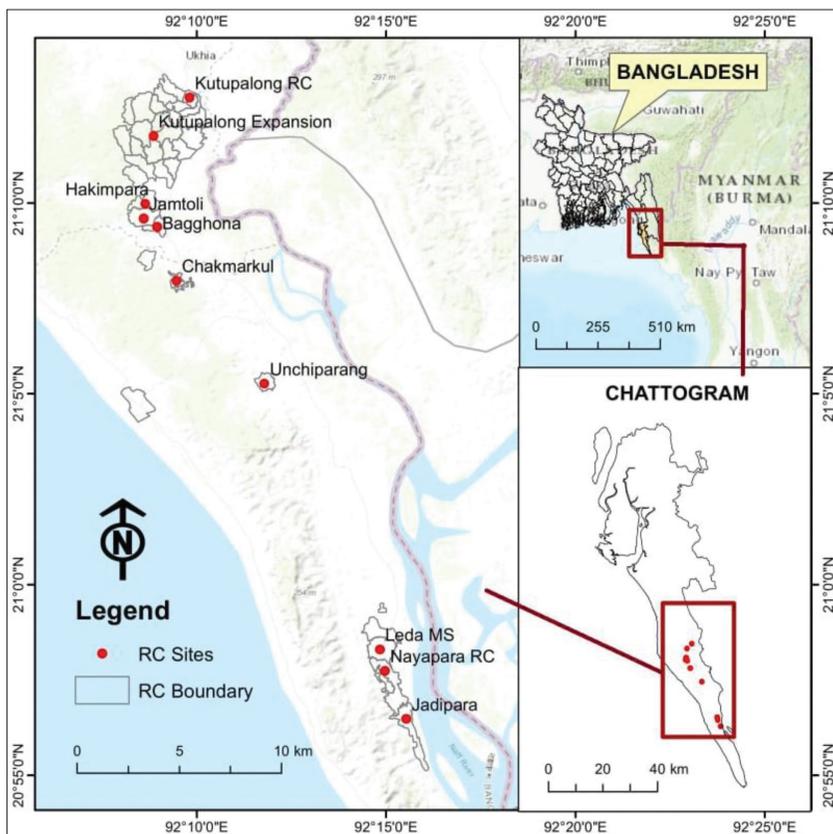
The anatomy of Rohingya camps and the COVID-19

Large-scale refugee camps which include Bangladesh (Cox's Bazar), Kenya (Dabaab, Hagadera, Dagahaley & Ifo), South Sudan (Yida), Tanzania (Katumba, Miahamo) (Ullah, 2011; 2014; Kagan, 2011; Katz, 2017), Ethiopia (Pugnido), Pakistan (Panian), and Palestine (Jabalia Camp, Beach camp) across the world are at risk of Covid-19. Coronavirus cases have been confirmed in many refugee camps in Bethlehem where Palestinian refugees are housed (Patel, 2020) including the Rohingya camps in Bangladesh. Globally, there are more than 64 million people of concerns (displaced and refugees) (Turner, 2018; Hopman, Allegranzi & Mehtar, 2020; Ullah, 2014; 2011; UNHCR, 2020) and are housed in various camps and outside of camps in many countries.

With the current COVID-19 pandemic affecting livelihoods and plunging the global economy into a recession, questions have arisen about the Rohingyas who are languishing in crowded refugee camps. The Rohingya camps house about 40,000 people per square kilometer (103,600 per square mile) where the refugees live in plastic shacks side by side (Myanmar Crimes, April 05, 2020). Each of the shacks in camps is barely 10 square meters (107 square feet) and most of them are overcrowded with up to 12 members (Ullah, 2011; Kreichauf, 2018). Thus, jam-packed camps with substandard healthcare and inadequate

access to proper sanitation have made the Rohingyas incredibly vulnerable to this virus attack (Nortajuddin, 2020).

Since March 26, 2020, the entire Cox’s Bazar district has gone under lockdown sine die (Kamruzzaman, 2020). The military has sealed off the camps while police and Rapid Action Battalion (RAB) have been patrolling inside. Only emergency health services and distribution of food aid are allowed in the camps. The Rohingyas are not allowed to roam about. Vehicles moving into the camps for emergency reasons are only allowed with proper permissions from higher authorities.



Map 1. Shows Rohingya camps in Cox’s Bazar, Bangladesh. Source: Authors, 2020

The UN agencies together with partner organizations are limiting their activities to essential services and assistances only, promoting hygiene activities, training healthcare workers, and ensuring social distancing across the camps (Kreichauf, 2018). While nations around the world are urging their citizens to self-isolate and practice social distancing of one metre apart, these measures seem to be a myth to implement as the width of most paths in Kutupalong camp is just two metres (Aljazeera, March 26, 2020). Also, masks, that have become a daily essential in much of the world, are rarely seen and sanitizers are something unheard of (The National, May 04, 2020).

Social distance framework: The WHO recommends that people stay at least one metre away from each other in order to protect against coronavirus. This is termed as social or physical distancing. Regular handwashing/disinfecting and social distancing are key in halting the spread of COVID-19 (Broom, 2020). The specific guidelines of the WHO are: Social distancing [at least 1 metre apart] is an effective protective measure against the coronavirus and measures to ensure people observe this are in force.

It is estimated that about one-third of the world's population is under lockdown in their own homes, and, in many countries the police is enforcing social distancing. Quarantine means restricting activities or separating people who are not ill themselves but may have been exposed to COVID-19 (Ullah, Nawaz & Chatteraj, 2020). The goal is to prevent spread of the disease at the time when people just develop symptoms. Isolation denotes separating people who are ill with symptoms of COVID-19 and may be infectious to prevent the spread of the disease and the social customs have been revamped by implementing a no-visitor policy and greeting without physical contact (no handshakes, no kisses, no hugs etc.). Flexible work hours or rotational shifts are being implemented in most countries. Workplace design has been changed, for example insertion of partitions to raise cubicle wall heights. Revisit and revise seating arrangements have been implemented, and meetings and classes are being held virtually (Omale, 2020).

Rohingya camps reality: Every refugee camp is different because every situation is different. Therefore, camp designs should be different depending on the situation though changes in the design might not be possible in the case the refugees have already settled on a site. Also,

the number of people living in a camp depends on the severity of crisis and the propinquity of the origin and the destination. When the number of refugees is in the hundreds of thousands, aid agencies try to set up smaller camps with populations of no more than 20,000 rather than one massive camp. Smaller camps are easier to manage when it comes to fire risks, security problems and the spreading of diseases (Ramadan, 2013; CBS, 2007; Ullah, 2014).

Refugee camps should be set up on sloped terrain that provides natural drainage. Camps are only meant for temporary solutions, giving refugees a place to live until they can safely return home (Isin & Rygiel, 2007). In general, the responsibility of security rests on the host governments. Refugees, of course, sometimes develop self-policing mechanism depending on the situation. In some cases, host governments insist on enclosing refugee camps with barbed wire fences so the refugees cannot blend in with the local population (Ullah, 2011; 2014; Steigemann, 2018). The camps should be accessible by road providing access to main facilities so supplies can be delivered to health centres, food storage, warehouses, and connection to communal latrines to allow for maintenance.

Camps should be constructed of local materials (such as wood, metal sheets, branches and plastic sheeting) so that repairing as needed does not become expensive and difficult. In some cases, refugees construct their own shelters with tools and other assistance provided (Ramadan, 2013; CBS, 2007).

In warm climates, the minimum ideal shelter space is 3.5 square metres per person. In this case, cooking is done outside. Alternatively, the space should be 4.5 to 5.5 square metres with cooking done inside (Ullah, 2014). In cold climates, there should be indoor kitchen and bathing facilities. The minimum allowable distance between shelters is two metres (Ullah, 2014; CBS, 2007). There should be at least one point for water dispenser for every 200 to 250 refugees, which should be no more than 100 metres from the camps. The minimum amount of water required in an emergency situation is at least one gallon of water per person per day, and this should be increased to five to six gallons per person as soon as possible so people have enough water for cooking, personal hygiene, and washing dishes and clothing (Agier, 2016; CBS, 2007).

Refugees should have a piece of document as a proof that they are a resident of the camp, which entitles them receiving food rations (Steigemann, 2018). They also should receive their first food package and other relief items, such as blankets, clothing and cooking utensils for immediate needs. Food distribution could be done at one location or broken up among several (i.e. dividing a population of 20,000 among four distribution points). Families receive basic rations that should be designed to meet cultural diets. The minimum recommended daily ration is 2,100 calories per person (Coddington, 2018; CBS, 2007; Ullah, 2011).

Health care includes access to a short list of essential drugs (30 to 40 at most), which are chosen because of their affordability and effectiveness in treating the main diseases the refugees could be afflicted with (CBS, 2007; Kagan, 2011). Some refugee camps have fully operational hospitals or highly developed clinics where doctors can perform complex procedures. A hospital or clinic usually serves a population of 200,000 (or one hospital per 10 refugee camps). Besides the main health centre, smaller health posts are set up throughout the camp. Each serves 3,000 to 5,000 refugees. Of course, this is not the case for Rohingya camps in Bangladesh. Ideally there should be one latrine per family. If public latrines are used, there should be at least one for every 20 people. The latrines should be away from water sources but no more than 50 metres from shelters. If the host country allows people to enter and leave the camp as they please, a camp may have a market. In the case of a closed camp, the government may still allow a market day when merchants are allowed in to sell their goods.

The challenges

We assessed the reality in the camps against the framework keeping the COVID-19 situation in mind. The fear that the virus will spread like wildfire soars high once one gets it. Cases are being detected since 15th May 2020 (BD News, May 15, 2020). Aid agencies are in the process of installing washing stations to reduce the spread of the virus (BD News, May 16, 2020). The question comes now what to choose— to stop entry and die without food or let them enter and die from the virus? Several camps are facing serious food and water shortages. While relief efforts are largely meeting their basic needs, life in the camps offers little more than survival, and many are desperate to escape to find work,

go to school, or reunite with the families they lost (Ullah & Chattoraj, 2020; Ullah, 2018).

The lockdown measures cut humanitarian workers in refugee camps by 80 percent and put the refugees at severe risk of food and water shortages and disease outbreak (Human Rights Watch, April 28, 2020). Access of outsiders to the refugee camps has been restricted (Aljazeera, March 26, 2020), however, restrictions on access to aid put the Rohingyas at greater risk. To add, restrictions on the internet and phone services have deterred refugees from seeking urgent medical care. Given the fact that the Rohingya refugees are not aware of the pandemic, lifting internet restrictions is important as this will help the refugees to keep themselves updated with information about Covid-19 and, also, how to lower the risks of a coronavirus spread in the camps (Nortajuddin, 2020). This has also led them to boredom.

The hardships of the camp dwellers have been apparent in the crowded rows of dilapidated bamboo-and-tarpaulin huts. Overflowing latrines, shortages of water and failures of sanitation are the major widespread complaints. Though, self-isolation is a must to combat Covid-19, yet in the camps there is simply no space to self-isolate (Loy, 2020). There are, however, some isolation centres reserved only for severe cases while others would be self-isolating at home. This implies that they risk an easy spread of the virus among family members in self-isolation at home since the scarce space they live in.

The exodus that has been taking place for the last three decades and latest and the largest wave have been adding the number to the exponential growth of the Rohingyas living in camps (Ahamed & Mercy, 2020). Unfortunately, defying the standard camp anatomy, most of Rohingya camps were erected in the vulnerable areas on and around the hilltops. The locations are exposed to landslide and torrential downpour.

There are no doubts that like other countries, refugee camps in Bangladesh are at risk for COVID-19. Given the proximity of the camps, managing non-communicable diseases and reducing the risk of COVID-19 in refugee camps could be close to impossible (Hopman, Allegranzi & Mehtar, 2020). There are only five clinics run by non-governmental organizations (NGOs), IOM and foreign governments

with a capacity of 340 beds, which are way less than their needs (IOM, 2020).

Conclusions

What is life like for the Rohingya refugees in their camps during the pandemic? How far can they maintain social distance given their propinquity in the camps? How practical is this to stop aid workers to go in? Since their food, security, water supply health services are entirely dependent on external sources, how could they maintain WHO prescribed framework of social distance? Most of the Rohingya refugees fled with only the clothes they were wearing and a few other items on foot during the brutal military persecution perpetrated upon them. All of them had horrific stories of hiding in various locations until the rampages ended and then fled toward the Bangladesh border. What does a normal day look like for these refugees? Most of the refugees sleep on hardened mud. Most of them are waken by someone passing by their camps on the way to get food to cook, water to drink, or to go to a latrine. This implies the fact that they are very close physically from each other.

Without safe and private hygiene spaces, women and girls are at high risk of COVID-19 infection. Though, the camp has been placed under lockdown concerns are growing among the refugees that as a number of them tested positive, there is no room to isolate oneself or for quarantine. Only 250 isolation beds have been set up in the camps whereas thousands of them can potentially get (BD News, May 16, 2020). Covid-19 has changed everything in the camps. The mosques are empty; children, instead of playing in the streets, are now confined to their huts and the bustling markets are quiet. Families are forced to ration food and spend all day together in cramped spaces. It is a worrying time for everyone in the camps. Refugee regimes and host governments may take a condign lesson on how to handle such a situation, if this ever appears again, without lest number of fatalities possible.

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