

**MedGlobal**

## **ROHINGYA REFUGEES & COVID-19:**

**Facing the Pandemic in the World's Most Densely  
Populated Refugee Camps**

**June 2020**



# ABOUT MEDGLOBAL

MedGlobal is a humanitarian non-governmental organization working to serve communities by providing sustainable, innovative, and free health-care services to refugees, displaced people, and vulnerable populations in crisis-affected areas and low resource settings. Launched in 2017, MedGlobal was established by a diverse group of doctors, nurses, and medics-experienced in humanitarian medicine and emergency services to address the health needs of the most vulnerable across the world. We work in humanitarian emergencies with a focus on collaborations with local health organizations, capacity building for local health professionals, and providing humanitarian and medical assistance. MedGlobal aims to create a world without healthcare disparity.

MedGlobal currently supports sustainable operations and local healthcare in Bangladesh, Colombia, Yemen, and Greece, as well as leading humanitarian responses in Gaza, Syria, and Pakistan. MedGlobal has also supported medical assistance programs in Mexico, Puerto Rico, Venezuela, Lebanon, Jordan, Sierra Leone, Turkey, Kurdistan region of Iraq, and more, altogether organizing 188 volunteer medical missions to 14 countries around the globe.

# ACKNOWLEDGEMENTS

Numerous MedGlobal staff, volunteers, and local partners contributed to this report through their expertise and information sharing. We particularly want to thank Dr. Rahana Parvin, MedGlobal Clinic Coordinator; Dr. Maryam Molla, former MedGlobal Field Coordinator; and Commander (Ret.) Ferdous Muhammed for their contributions to this report and outstanding dedication to supporting the healthcare of those in need in Cox's Bazar. We want to thank the Health Sector, of which we are proud to be a member, particularly as they play a critical leading role in coordinating the COVID-19 response and sharing critical information. This report was co-written by Emma Forte Sczudlo, MedGlobal Missions Coordinator, and Kathleen Fallon, MedGlobal Advocacy Advisor.

We want to give special thanks and appreciation to our local partners on the ground, particularly OBAT Helpers, with whom we are humbled and proud to partner for the health and wellbeing of Rohingya refugees and host communities. We give special thanks to all of our donors, especially the Latter Day Saints Charities who have supported our programs to provide health care to Rohingya refugees. We thank the Bangladeshi people and government for opening their border and homes to nearly 1 million Rohingya refugees, in spite of limited resources, and encourage all governments to follow their lead.

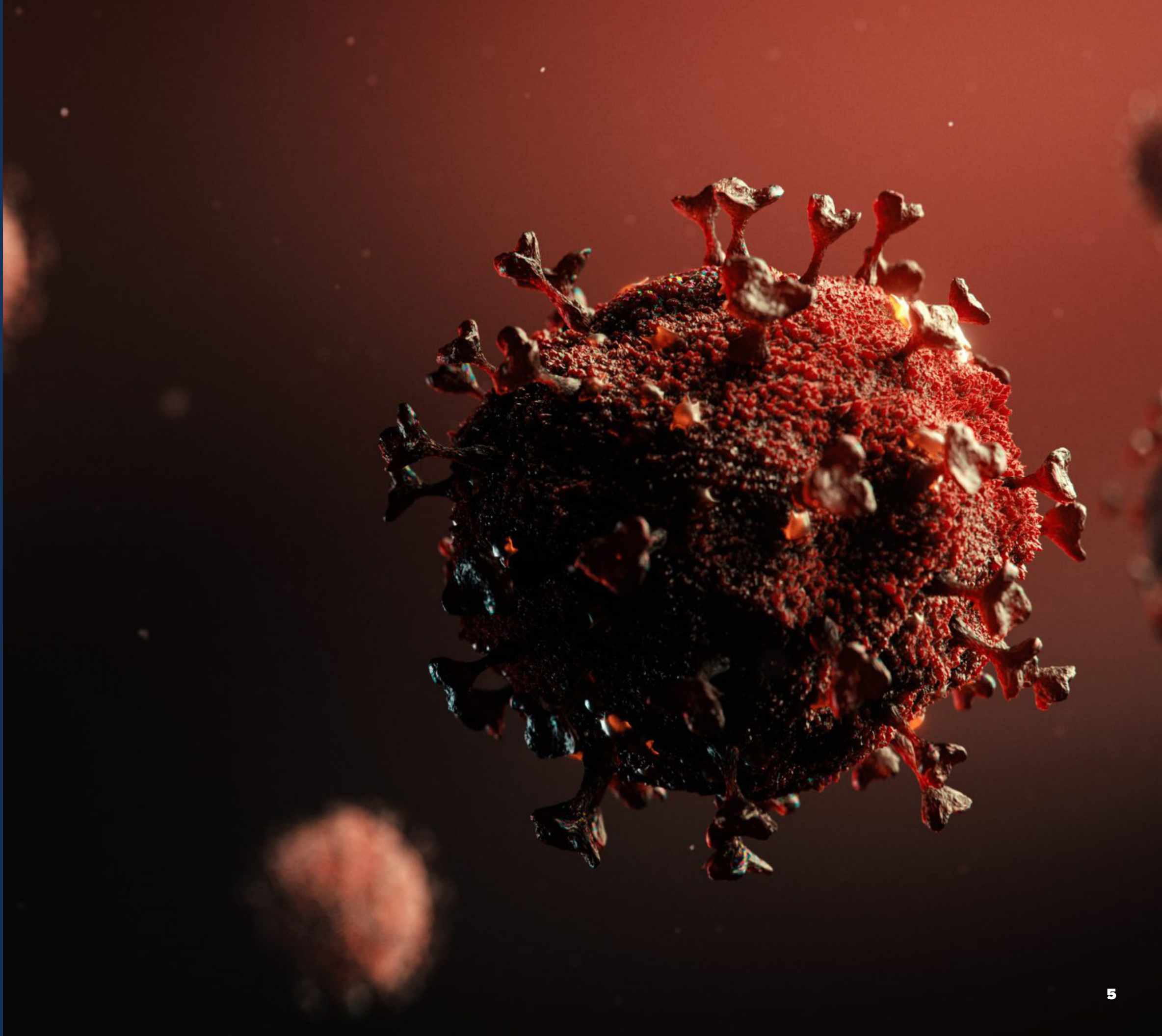
**We want to dedicate this report to the more than 860,000 Rohingya refugees in the Cox's Bazar refugee camps, most of whom have survived atrocities in Myanmar and continue to face extreme hardships as refugees, the latest of which is the COVID-19 pandemic.**





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# EXECUTIVE SUMMARY

As COVID-19 spreads worldwide, it has the most dire impact on vulnerable communities. The camps in Cox's Bazar, Bangladesh have the highest concentration of refugees in the world, with over 860,000 Rohingya refugees. The living conditions in these camps are grim, with a high population density, poor sanitation facilities and water quality, and lack of medical facilities. Even before the COVID-19 pandemic, Rohingya refugees faced an ongoing health crisis.

**Now, we are seeing the beginning of a much-feared COVID-19 outbreak in the Rohingya refugee camps.** On May 14, the first cases of COVID-19 were confirmed inside the camps. On May 31, an elderly Rohingya man became the first person to die from COVID-19 in the refugee camps while he was undergoing treatment in an isolation center. <sup>1</sup>With the severe overcrowding in the camps, there are widespread fears that COVID-19 will spread at an alarming rate.

• **40 confirmed cases among Rohingya refugees in the camps**

• **1,732 confirmed cases among Cox's Bazar host community members**

• **436 tests conducted for Rohingya refugees (4.1% of total tests in Cox's Bazar district)<sup>2</sup>**

MedGlobal has been working in Cox's Bazar since 2017, serving more than 112,300 Rohingya refugees and vulnerable members of the Bangladesh host community with health care. At the onset of the COVID-19 pandemic, MedGlobal prepared a needs assessment for our field team in Cox's Bazar related to key needs for COVID-19 preparedness and response.

**Based on these needs assessments and information coming from the Health Sector, this report explores key considerations for the COVID-19 response for Rohingya refugees, outlines a table of key needs (found on page 14), and puts forth recommendations.**

Key local considerations are critical to inform the COVID-19 crisis response, and include Rohingya local knowledge and perceptions, the impact of scaling down other health services, Cox's Bazar travel limitations, WiFi connectivity restrictions, and monsoon season. We have identified several recommendations for how health focused NGOs and international organizations should adapt during the COVID-19 crisis:

- Scale up the COVID-19 prevention and response work.
- Maintain core health services.
- Promote a needs-based reassignment of health workers.
- Adapt services to use alternate modalities for care.
- Adjust standard clinic operations such as facility mapping for social distance.
- Prioritize protection of the most vulnerable.
- Expand mental health programming.
- Ensure local knowledge and religious beliefs inform the COVID-19 response.
- Work to increase community confidence in health services.
- Scale up community-based surveillance.

For governments, including donor governments and the Bangladesh host government, we put forth the following recommendations:

- Allow full access for humanitarians and health workers into the camps.
- Improve internet connectivity in the camps.
- Improve information sharing processes related to COVID-19 with Rohingya refugees.
- Maintain funding for core health services.
- Allow flexible funding.
- Reiterate that there should be no forced return of refugees.

Rohingya refugees have faced ethnic cleansing, forced displacement, and overcrowded conditions in the world's largest refugee settlement. Now, they face a COVID-19 outbreak. An immediate and comprehensive response is needed from the international community to stop preventable deaths. These communities must not be forgotten.



<sup>1</sup> Al Jazeera. "First Rohingya refugee dies from coronavirus in Bangladesh." June 17, 2020. <https://www.aljazeera.com/news/2020/06/rohingya-refugee-dies-coronavirus-bangladesh-camps200602095409310.html>

<sup>2</sup> Information from Cox's Bazar Health Sector.

<sup>3</sup> UNHCR. "Joint Government of Bangladesh - UNHCR Population Map." April 30, 2020. <https://data2.unhcr.org/en/documents/details/76155>

<sup>4</sup> UNOCHA. "Rohingya Refugee Crisis." Accessed May 20, 2020. <http://www.unocha.org/rohingya-refugee-crisis/>

# BACKGROUND



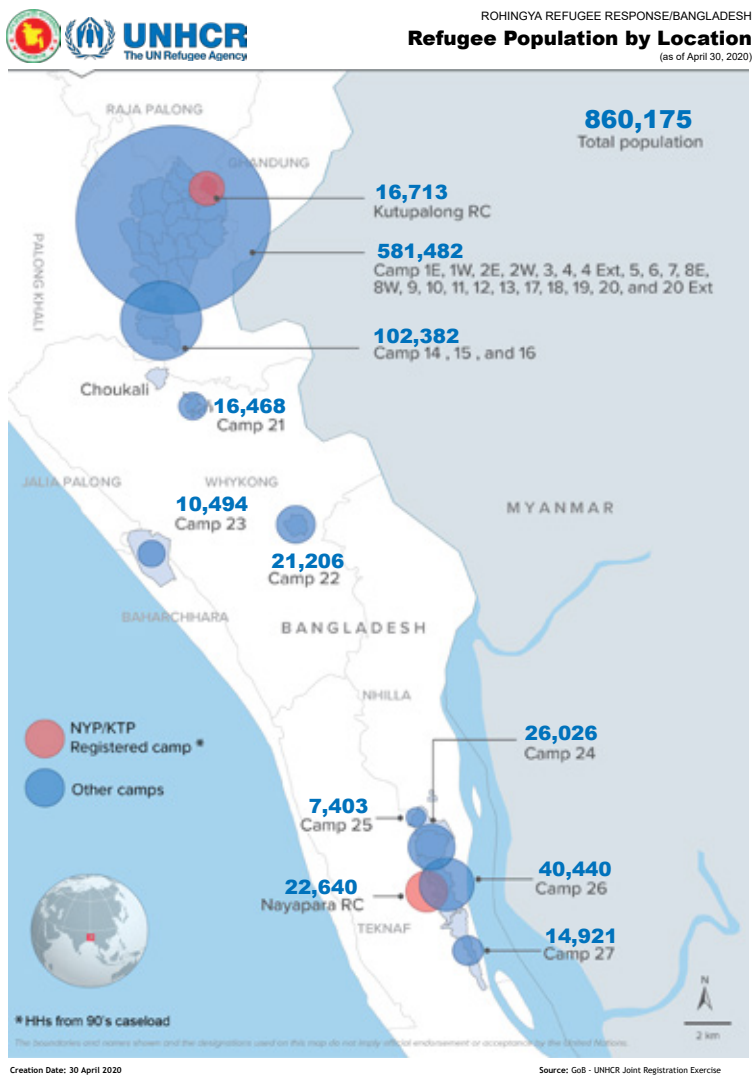
**Over 860,000 Rohingya refugees in Cox's Bazar<sup>3</sup>**



**Cox's Bazar has among highest concentration of refugees in the world<sup>4</sup>**



**Average population density: 103,600 Rohingya refugees per square mile<sup>5</sup>**



The Rohingya, a largely Muslim ethnic minority, have faced decades of statelessness, discrimination, and violence in Myanmar. Before recent waves of displacement, an estimated 1 million Rohingya lived in Myanmar, primarily in its western Rakhine State.<sup>6</sup> Rohingya families in Myanmar faced numerous barriers to accessing healthcare - a lack of health workers, badly maintained roads, poorly equipped and staffed hospitals, restrictions on movement, and discriminatory practices in hospitals, such as segregated hospital wards.<sup>7</sup> In August 2017, a renewed campaign of ethnic cleansing and atrocities against the Rohingya in Myanmar began, which the UN Independent International Fact-Finding Mission on Myanmar concluded to be crimes against humanity and other grave human rights violations.<sup>8</sup> This not only led to widespread death and suffering, but also to the fastest refugee influx from Myanmar to Bangladesh, with almost 700,000 Rohingya fleeing to Bangladesh in less than a year.

**Now, there are over 860,000 Rohingya refugees in the formal and informal camps around Cox's Bazar, including over 625,000 crowded in the Kutupalong-Balukhali Expansion Site.** Cox's Bazar was already one of Bangladesh's poorest districts, and the addition of hundreds of thousands of refugees has created a further strain on the host community. There are 34 camps and settlements across Cox's Bazar district.

The living conditions in these refugee camps are dire, with poor sanitation facilities and a shortage of soap, extreme overcrowding, poor water quality, and lack of medical facilities. Tents and houses are often built out of bamboo frames and plastic tarps, with many built on slopes or flood-prone low-lying areas, and the camps are not adequately equipped to handle the summer monsoon and cyclone seasons. Poor water and sanitation in the camps, as well as the crowded condition, increase the likelihood of communicable and waterborne diseases spreading among refugee families. **Comprehensive health care was one of the greatest needs among refugees even before the COVID-19 pandemic.**

<sup>5</sup> ACAPS. "COVID-19 Rohingya Response." March 19, 2020. [https://reliefweb.int/sites/reliefweb.int/files/resources/20200319\\_acaps\\_covid19\\_risk\\_report\\_rohingya\\_response.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/20200319_acaps_covid19_risk_report_rohingya_response.pdf)

<sup>6</sup> Milton, Abul Hasnat et al, "Trapped in Statelessness: Rohingya Refugees in Bangladesh," International Journal of Environmental Research and Public Health 14.8 (2017): 942. PMC.

<sup>7</sup> Amnesty International. "Caged Without a Roof: Apartheid in Myanmar's Rakhine State." November 2017. <https://www.amnesty.org/en/documents/asa16/7484/2017/en/>

<sup>8</sup> A/HRC/39/64, Report of the Independent International Fact-Finding Mission on Myanmar, para 88.



# SITUATION DURING COVID-19



**436 tests for Rohingya refugees**  
conducted in the camps  
as of June 17 <sup>9</sup>



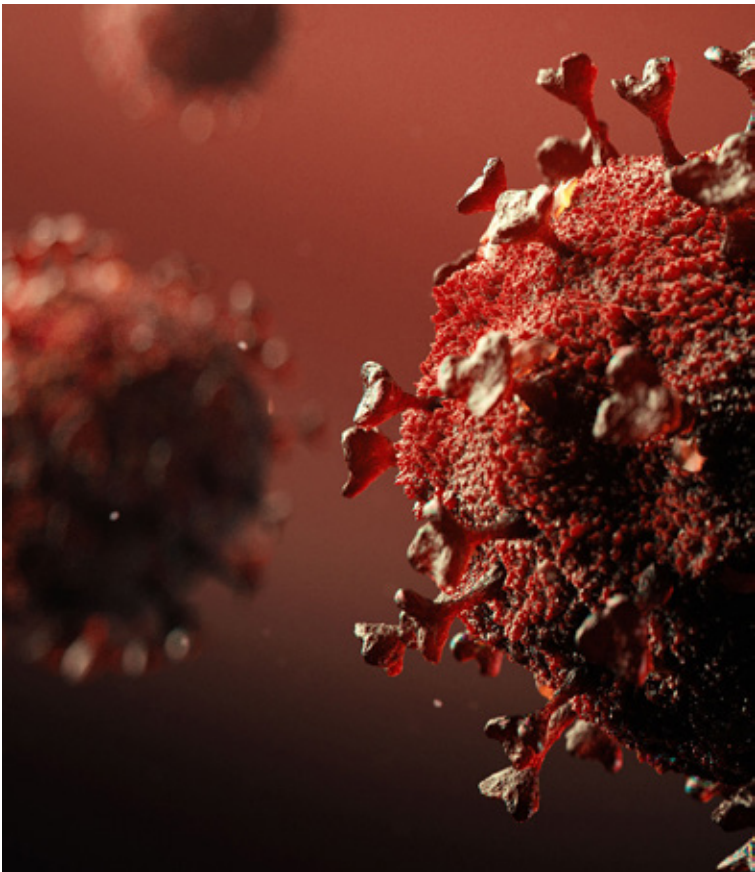
**40 confirmed COVID-19 cases**  
among Rohingya refugees  
as of June 17



**1,732 confirmed COVID-19 cases**  
in Cox's Bazar host community  
as of June 17



**3 deaths from COVID-19**  
among Rohingya refugees  
as of June 17



Bangladesh is one of the most densely populated countries in the world, which has made facing and containing the COVID-19 pandemic an incredible challenge. After it was confirmed that the virus had spread to Bangladesh in March, the government instituted a nationwide shut-down. As of June 17, there have been 108,775 confirmed cases of COVID-19 in Bangladesh, and 1,425 deaths from COVID-19.<sup>10</sup> The Bangladeshi host community in Cox's Bazar was impacted by COVID-19 before the virus reached the refugee camps, and as of June 17, there have been 1,732 confirmed cases of COVID-19 within Cox's Bazar host community.

The first cases of COVID-19 were confirmed inside the Rohingya refugee camps on May 14, and as of June 17 there are 40 confirmed cases in the camps. **On May 31, a 71-year-old Rohingya man became the first person to die from COVID-19 in the refugee camps while he was undergoing treatment in an isolation center.**<sup>11</sup> As of June 17, there have been 40 reported deaths from COVID-19 in the camps, all men between the ages of 56 to 71.<sup>12</sup>

**Now that COVID-19 is present in the camps, there are fears that it will spread at an alarming rate.** A recent report from the Johns Hopkins University Center for Humanitarian Health forecasts between 424,798 and 591,349 cases and between 1,515 and 2,109 deaths from COVID-19 in the Kutupalong refugee camp within 12 months of the virus being introduced into the camps.<sup>13</sup> The extreme overcrowding within the Kutupalong refugee camp, which has an average population density of approximately 40,000 people per square kilometer, or 103,600 people per square mile, makes social distancing impractical. Similarly, the poor hygiene and sanitation options prevent residents from being able to adequately practice infection prevention and control. One hopeful mitigating factor is the demographic breakdown by age - only 3.6% of the Rohingya refugee population in Cox's Bazar camps is over the age of 60, which is the most at-risk age range for COVID-19 mortality.<sup>14</sup>

The overarching response for affected communities in Cox's Bazar, including both Rohingya refugees and host communities affected by the crisis, is coordinated by the government of Bangladesh, particularly the Refugee Relief and Repatriation Commissioner (RRRC) and the District Commissioner (DC), and humanitarian stakeholders, managed by the Inter Sector Coordination Group (ISCG).<sup>15</sup> All COVID-19 responses are guided by the national Preparedness and Response Plan for COVID-19.<sup>16</sup> As of June 17, 10,634 tests have been conducted in Cox's Bazar, though only 436 of these tests (4.1%) were for Rohingya refugees.<sup>17</sup> Movement into and out of the refugee camps is highly regulated. Before COVID-19 entered the refugee camps, this regulation made Rohingya refugees less likely to be exposed to COVID-19. This, in part, led to Rohingya with flu-like symptoms being less likely to be tested. Symptomatic Rohingya were sometimes isolated, but they were not tested.



<sup>9</sup> Information from Cox's Bazar Health Sector

<sup>10</sup> WHO. "WHO Coronavirus Disease (COVID-19) Dashboard." Accessed June 12, 2020. <https://covid19.who.int/>

<sup>11</sup> Al Jazeera. "First Rohingya refugee dies from coronavirus in Bangladesh." June 2, 2020.

<https://www.aljazeera.com/news/2020/06/rohingya-refugee-dies-coronavirus-bangladesh-camps-200602095409310.html>

<sup>12</sup> Information from Cox's Bazar Health Sector

<sup>13</sup> Johns Hopkins Center for Humanitarian Health. "COVID-19: Projecting the impact in Rohingya refugee camps and beyond." March 25, 2020. [http://hopkinshumanitarianhealth.org/assets/documents/COVID-19\\_\\_Rohinya\\_Refugees\\_\\_Beyond\\_-\\_Summary\\_FINAL\\_March\\_25\\_2020.pdf?fbclid=IwAR0y3-ZoIDrXBdp6I949R7yqZDx5UZMpFrDMOgoccdDxIKlrwCG1Qs3Co30](http://hopkinshumanitarianhealth.org/assets/documents/COVID-19__Rohinya_Refugees__Beyond_-_Summary_FINAL_March_25_2020.pdf?fbclid=IwAR0y3-ZoIDrXBdp6I949R7yqZDx5UZMpFrDMOgoccdDxIKlrwCG1Qs3Co30).

<sup>14</sup> UNHCR. "Population Figures." April 30, 2020. [https://data2.unhcr.org/en/situations/myanmar\\_refugees](https://data2.unhcr.org/en/situations/myanmar_refugees)

<sup>15</sup> Strategic Executive Group. "2020 Joint Response Plan for Rohingya Humanitarian Crisis January - December." 2020. [http://reporting.unhcr.org/sites/default/files/2020%20JRP%20-%20March%202020\\_0.pdf](http://reporting.unhcr.org/sites/default/files/2020%20JRP%20-%20March%202020_0.pdf)

<sup>16</sup> Government of the People's Republic of Bangladesh. "National Preparedness and Response Plan for COVID-19, Bangladesh." March 2020. <https://reliefweb.int/report/bangladesh/national-preparedness-and-response-plan-covid-19-bangladesh>

<sup>17</sup> Information from Cox's Bazar Health Sector



Quarantine Sites and Isolation Units for Rohingya Refugees in Cox’s Bazar District

Isolation Units <sup>18</sup>	11 isolation units	114 active beds in isolation units	50 planned beds in isolation units
SARI Units <sup>18</sup>	11 Severe Acute Respiratory Infection (SARI) units	254 active or standby SARI beds	800 planned SARI beds
Quarantine Units <sup>19</sup>	6 Quarantine Sites	Capacity of 488 families	Capacity for 2,440 individuals



Home-based care is set to begin once the SARI facilities reach a 75% bed capacity. At clinics within the camps, and hospitals outside of camps, the overall shortage of medical supplies, equipment, medications, hospital beds, and intensive care units will inevitably hinder effective treatment of large numbers of patients.

<sup>18</sup> These data are as of June 9, 2020 and were provided by the Health Sector.  
<sup>19</sup> These data are as of May 20, 2020 and were provided by the Health Sector.

# MEDGLOBAL’S HEALTH WORK WITH ROHINGYA REFUGEES

Since October 2017, MedGlobal has worked in partnership with national and international NGOs to serve more than 112,300 Rohingya refugees and vulnerable Bangladeshis living in Kutupalong refugee camp. MedGlobal runs a clinic in the refugee camp with the NGOs OBAT Helpers and Prantic, and had previously partnered with the NGO Hope Foundation for Children. Before the COVID-19 pandemic, MedGlobal coordinated with teams of physicians, nurses, and public health workers to provide free and sustainable care at the clinic. A total of 113 medical professionals have volunteered with MedGlobal at the Kutupalong refugee camp since 2018.

MedGlobal provides a range of health services, including primary care, particularly for the management of chronic diseases like diabetes, hypertension, and asthma; pediatric care, including services for children with malnutrition; women’s health services, including family planning and reproductive health care; free medications; laboratory tests and point of care testing; and health education for patients on common medical conditions. In addition to providing medical services, MedGlobal has led training in the resuscitation technique to reduce neonatal mortality called “Helping Babies Breathe” and community-based mental health training on trauma-informed care.



“Since 2017, MedGlobal has partnered with local Bangladeshi NGOs to build resilience among the host community and refugees to better cope with one of the worst refugee crises in modern time. We are scaling up our support during the COVID-19 pandemic and beyond.”

- Dr. Hena Ibrahim,  
MedGlobal Executive Director



# MEDGLOBAL'S COVID-19 RESPONSE FOR ROHINGYA REFUGEES



Throughout the COVID-19 pandemic, MedGlobal's clinic has remained open to provide ongoing care for the community. This is critical, as our clinic is the only healthcare option for many of our patients. At the onset of the COVID-19 pandemic, MedGlobal prioritized infection prevention and control. Repairs to the plumbing at our clinic were prioritized, to ensure that clean running water would not be an issue for health care providers. Staff also completed clinic mapping to incorporate social distancing between those in the clinic, and they launched daily clinic chlorination for disinfection.

MedGlobal has also provided 1,875 disposable sets of personal protective equipment (PPE), 10 reusable sets of PPE, 3,000 surgical masks, and 5 infrared thermometers to our clinic. As with all of the medications, supplies, and equipment that we use at the clinic, MedGlobal procures PPEs from local suppliers.

Our clinic has established triage procedures and clinical management protocols based on World Health Organization recommendations. MedGlobal has initiated two webinar series for clinic staff - the first is on COVID-19 management practices including PPE use, screening and triaging patients, clinical management, and sample collection and testing, and the second is on mental health, providing tips for clinic staff to promote their own mental health and that of their patients. MedGlobal staff at our clinic also began health education sessions for patients on topics including handwashing, social isolation, and COVID-19 symptoms.



## METHODS

**At the onset of the COVID-19 pandemic, MedGlobal prepared needs assessment questionnaires for all field offices and partners. The needs assessment was broken down by categories outlined by the United Nations High Commissioner for Refugees (UNHCR) and included:**

- 1** Infection prevention and control
- 2** Risk communication and community engagement
- 3** Epidemiological surveillance, rapid response, and case investigation
- 4** Case management
- 5** Protection monitoring
- 6** Country-level coordination, planning, and monitoring



Upon receiving the completed needs assessments, the MedGlobal team assessed responses to identify key needs related to COVID-19. This information informs our ongoing operational response, and informed the Key Consideration for the COVID-19 Response, Key Needs, and Recommendations sections of this report.



# KEY CONSIDERATIONS FOR THE COVID-19 RESPONSE

## Rohingya Considerations for Health Care

The COVID-19 response in the refugee camps in Cox's Bazar should take into consideration Rohingya perceptions on health care, cultural values, and health literacy, especially relating to social isolation and management of dead bodies. Research has found that Rohingya are frequently more comfortable accessing health services and systems similar to those accessed in Myanmar. For example, the referral system in Bangladesh differs from Myanmar, where it is more common to see a single provider for comprehensive care, and can cause skepticism among Rohingya. Similarly, there is distrust and skepticism among many Rohingya about the quality of health services provided by some humanitarian agencies in the camps.<sup>20</sup> It is also important to consider the Rohingya's culture and religious beliefs. Research led by the International Organization on Migration and ACAPS explored Rohingya perceptions of COVID-19 and treatment, and found that for many, a deep trust in "Allah's will" influences every belief about COVID-19.<sup>21</sup> This underscores the importance of incorporating local knowledge and Rohingya religious traditions, which have been a key coping strategy for dealing with crises, into the COVID-19 response to develop a more nuanced and effective approach.

## Impact of Scaling Down Other Health Services

The urgency of the COVID-19 response has caused service providers to scale down primary and secondary health services as they are forced to divert resources. The health facilities in the Cox's Bazar camp and the district hospital had limited human, financial, and supply resources before the pandemic began. The use of medicine, equipment, personnel, and hospital beds for COVID-19 patients will hinder the effective treatment of patients facing other illnesses. In particular, an increase in vaccine-preventable diseases and potentially in maternal and child mortality is feared. According to the Health Sector, there has already been a decline in routine immunization coverage in Cox's Bazar due to the halting of outreach for immunization sessions, a decrease in regular vaccine supplies, and the deployment of immuniza-

**"There is rising fear and panic among the community which is making screening ineffective as patients are too afraid to admit they have any symptoms similar to COVID... [Many also] deny or purposefully hide their history of travel. As a result [the] number of infections among health care workers are rising very rapidly."**

**- Dr. Maryam Molla, former MedGlobal Field Coordinator**

tion staff to the COVID-19 response, among other reasons. Further, many of those who are suffering from non-COVID related illness are expected to delay seeking care or fully avoid health centers for fear of contracting or even being diagnosed with COVID-19.

## Cox's Bazar Travel Limitations

Since 2019, there have been various levels of travel restrictions for humanitarians entering the Kutupalong refugee camp, and strict restrictions for refugees leaving the camp. In September 2019, plans were announced to construct



**"Some organizations have limited their services so that they can increase inpatient capacity and allow social distancing. Some Rohingya are suffering because they may have symptoms but cannot go to the facilities."**

**- Dr. Rahana Parvin, MedGlobal Clinic Coordinator**

barbed-wire fencing and guard towers around the refugee camps. Checkpoints have appeared around the camps. Since the start of the pandemic, heightened movement restrictions have been in place to mitigate the risk of COVID-19 transmission, with Cox's Bazar district being under lockdown since early April. While these measures have been adopted to prevent the spread of COVID-19, they had the effect of cutting the presence of humanitarian workers in the refugee camps by 80%.<sup>22</sup> These restrictions could impede health care workers trying to enter the camps and delay urgent health responses.

In April, a digitized pass system was approved by the Refugee Relief and Repatriation Commissioner to monitor the entrances of vehicles into camps. MedGlobal staff were prohibited from entering the Kutupalong refugee camp for a number of days beginning on April 2, as there were delays in obtaining a pass. On June 9, Cox's Bazar was divided into 12 wards, each classified as a "infected" or "highly infected" zone. Residents of the highly infected zones are currently prohibited from leaving their homes. There are reports of health care workers living in red zones who can no longer travel to facilities to provide care.

## WiFi Connectivity

Since the beginning of September 2019, Bangladesh authorities have imposed severe internet and phone restrictions on the refugee camps in Cox's Bazar and banned the sale of SIM cards to Rohingya refugees. The internet restrictions inside the camps have been a near blackout. This has greatly affected Rohingya refugees in the camps, particularly as there is a similar internet blackout in much of the Rakhine state

of Myanmar, and has made it difficult for humanitarian workers to coordinate the response. Information sharing with refugees about critical issues, including the timing of cyclones during summer monsoon season and COVID-19 updates, is made more challenging. The lack of connectivity has made preventative and awareness-raising measures, which could have been communicated over text message or phone, something that health workers must take on largely in-person, which puts their health at risk.

## Monsoon Season

Cox's Bazar district has one of the highest rainfalls in Bangladesh during monsoon season.<sup>23</sup> The monsoon season occurs in the summer months, typically between May and September, and includes heavy rainfall, strong winds, and oftentimes cyclones. Cyclones and monsoons can destroy camp infrastructure or make medical care inaccessible, which exacerbates health needs. The annual monsoon season risks causing casualties and creating landlocked refugee communities, unable to access assistance because of flooding. Many new health challenges often surface during these months from the intense rain and storms, flooding, water stagnation, and contamination of water due to the destruction of water purification units and latrines. On May 20, Cyclone Amphan hit the coast of India and Bangladesh with deadly effects, and there is an ongoing risk that more cyclones will occur.



<sup>20</sup> ACAPS. "Rohingya Response: Health behaviours & COVID-19." April 3, 2020. [https://www.acaps.org/sites/acaps/files/products/files/20200403\\_acaps\\_rohingya\\_response\\_health\\_behaviours\\_covid\\_19\\_0.pdf](https://www.acaps.org/sites/acaps/files/products/files/20200403_acaps_rohingya_response_health_behaviours_covid_19_0.pdf).

<sup>21</sup> IOM and ACAPS. "Overview of Rohingya Perceptions." March 26, 2020. <https://reliefweb.int/sites/reliefweb.int/files/resources/Covid-19%20Explained%20Edition%201.pdf>.

<sup>22</sup> Human Rights Watch. "Bangladesh: Covid-19 Aid Limits Imperil Rohingya." April 28, 2020. <https://www.hrw.org/news/2020/04/28/bangladesh-covid-19-aid-limits-imperil-rohingya>

<sup>23</sup> Solace Global. "2018 South Asia Monsoon Season Report." May 2018. <https://www.solaceglobal.com/report/2018-south-asia-monsoon-season/>.



# KEY NEEDS

This table outlines needs that were identified through the MedGlobal needs assessment and Health Sector updates. Needs are categorized based on UNHCR’s six priority needs and areas of intervention.

<b>Priority Area 1:</b> Infection Prevention & Control	Clean running water at all clinics
	Full staffing of isolation units and quarantine centers
	Widespread distribution of soap for handwashing
	Additional personal protective equipment (PPE)
	Sanitizing supplies
<b>Priority Area 2:</b> Risk Communication and Community Engagement	Education for health care providers at quarantine facilities on identifying COVID-19 symptoms amongst individuals in quarantine and referring them to appropriate care
	Improved mobile and internet connectivity in Kutupalong refugee camp
<b>Priority Area 3:</b> Epidemiological Surveillance, Rapid Response, and Case Investigation	Improved estimates on acute respiratory infections (ARIs) <sup>24</sup>
	Additional COVID-19 testing capacity, including the procurement of additional PCR machines and laboratory staff
<b>Priority Area 4:</b> Case Management	Support for local healthcare providers as they treat patients (e.g. telemedical platforms to connect local providers with pulmonary specialists)
	Dedicated facilities for managing cases outside of clinics/ hospitals
	Additional severe acute respiratory infection (SARI) facilities
	Additional ICU beds
	Oxygen cylinders, generators, concentrators, and high-flow nasal cannula
	Human resources, especially health care providers and lab personnel
<b>Priority Area 5:</b> Protection Monitoring	Mental health services for local health care providers
	Messaging and programming to prevent and address social stigma associated with COVID-19
	Integration of protection programming in the health response (particularly considerations around age, gender, and disability)
<b>Priority Area 6:</b> Country-Level Coordination, Planning, and Monitoring	Strengthened diagnostic capacity at the divisional and district levels
	Increased advocacy for the needs refugees at the district and national levels

<sup>24</sup> Acute respiratory tract infections (ARIs) can be a sign of COVID-19 in lieu of widespread testing. ARI rates are currently reported through the weekly Epidemiological Bulletin published by the Health Sector, but the number of reported ARIs has dropped sharply since mid-March 2020. This is likely due to fewer people visiting health clinics because of self-isolation measures and fear of COVID-19.

# RECOMMENDATIONS

Based on the feedback from local MedGlobal staff and health workers, as well as Health Sector partners, we have identified several ways that health services could be adapted during the COVID-19 crisis to optimize the response. Here are our recommendations for health focused NGOs and international organizations (IOs) working with refugees in Cox’s Bazar, the Bangladesh government, and all donor governments.

## To health focused NGOs and IOs working in Cox’s Bazar:

- **Scale up the COVID-19 prevention and response work.** Rohingya refugees in the overcrowded camps of Cox’s Bazar and health workers who treat them are at great risk of contracting COVID-19 now that there are cases in the camps. NGOs and IOs should increase support for quarantine and isolation centers, telemedicine training on patient management best practices, and the provision of a full range of supplies. It is particularly critical to increase the number of ICU beds in Cox’s Bazar and the supply of oxygen cylinders, generators, concentrators, and high-flow nasal cannula.
- **Maintain core health services.** In addition to the COVID-19 response, it is important that all core primary health services, including vaccinations, are available for Rohingya refugees in the Cox’s Bazar camps.
- **Promote a needs-based reassignment of health workers.** Due to stay-at-home orders, clinics in Cox’s Bazar may continue to experience a reduction in patient visits. When possible, health facilities should reassign staff who are not needed at this time to work at the new quarantine centers. There is also a need for staff to support the Home-Based Care initiative, for which approximately 2,000 community health workers and 4,000 other health workers are needed.
- **Adapt services to use alternate modalities for care.** As in-person health care in clinics becomes less feasible and presents new safety issues, virtual and home-based services are among the alternatives. It is important to increase the number of hotlines and phone consultations, digital health outreach and education, telemedicine options, and home and mobile clinic services.

“During an overwhelming pandemic, it is expected that governments focus on the health needs of their own population. But we should not forget the most vulnerable, many of whom are refugees. Directing more resources to the Rohingya refugees during the COVID-19 pandemic in Bangladesh is crucial. It is consistent with best practices for health security and the right thing to do.”

- Dr. Zaher Sahloul,  
MedGlobal President





• **Adjust standard clinic operations.** COVID-19 best practices should be implemented in all clinics, including facility mapping for social distancing, strict appointment times, and a limit on the number of patients in waiting rooms.

• **Prioritize protection of the most vulnerable.**

The COVID-19 pandemic is exacerbating the suffering and isolation of the most vulnerable, including sexual and gender-based violence survivors, the elderly, and persons with disabilities. In addition to a comprehensive COVID-19 response, organizations should scale up robust, inclusive, and gender-sensitive protection programming in the Cox’s Bazar camps and promote the participation of women in leadership roles in the health response.

• **Expand mental health programming.** Mental health programming is key for those in isolation and for healthcare providers. Working with community leaders, it is important to identify culturally salient interventions to address the mental health effects of this pandemic, widespread fear, and social isolation.

• **Ensure local knowledge and religious beliefs inform COVID-19 response.** It is important that Rohingya local knowledge, perceptions, culture, and religious beliefs in-

form and are meaningfully incorporated into the COVID-19 response. Messaging should also work to lessen the stigma of the virus, which can lead to a delay in seeking treatment or hiding illness to avoid discrimination.

• **Work to increase community confidence in health services.** Health facilities and organizations should take measures to increase Rohingya community confidence in health services, including engaging community influencers, sensitizing all health facility staff, making waiting areas more uplifting and informative (i.e. playing music, displaying pictorial information about COVID-19), and encouraging patients to share real-time feedback with health facility staff.

• **Scale up community-based surveillance.** Community-based surveillance for acute respiratory tract infections (ARIs), which can be a sign of COVID-19 in lieu of widespread testing, should be scaled up. The rate of ARIs reported in Cox’s Bazar saw a steep decline around March 2020, likely connected to people staying home in observance of the quarantine. Increased community-based surveillance would allow tracking of individuals with ARIs who are not seeking health care in facilities and could help inform and expand preventative measures.

**To the Bangladesh government:**

• **Allow full access for humanitarian and health workers into the camps.** The Bangladesh people and government have opened their borders and homes to nearly 1 million Rohingya refugees over the last three years. During this COVID-19 pandemic, many governments, including Bangladesh, are putting forth certain travel restrictions for the safety of all people and to prevent transmission. However, humanitarian and health workers in Bangladesh must be given allowances to enter the Cox’s Bazar camps for health purposes without facing undue restrictions for the health of Rohingya refugees and the local host communities.

• **Improve internet connectivity in the camps.** Improving internet connectivity within the Kutupalong refugee camp is critical for COVID-19 prevention and response communication. The restrictions around internet connectivity and SIM cards should be reversed, which would better allow refugees to keep informed about the situation and health organizations such as MedGlobal to provide health information around virus transmission, patient management, and more via on-line platforms, such as telemedicine.

• **Improve information sharing processes related to COVID-19 with Rohingya refugees.** It is critical that all stakeholders leading in the COVID-19 response, including government authorities, emphasize widespread information sharing of COVID-19 prevention strategies.

**To all donor governments:**

• **Maintain funding for core health services.** It is critical for donors to maintain funding for existing health services, particularly primary health, in addition to scaling up funding for the COVID-19 response.

• **Allow flexible funding.** There should be increased flexibility for funding and partner agreements during this fast-changing time, including a higher degree of flexibility for changing line items and unforeseen costs.

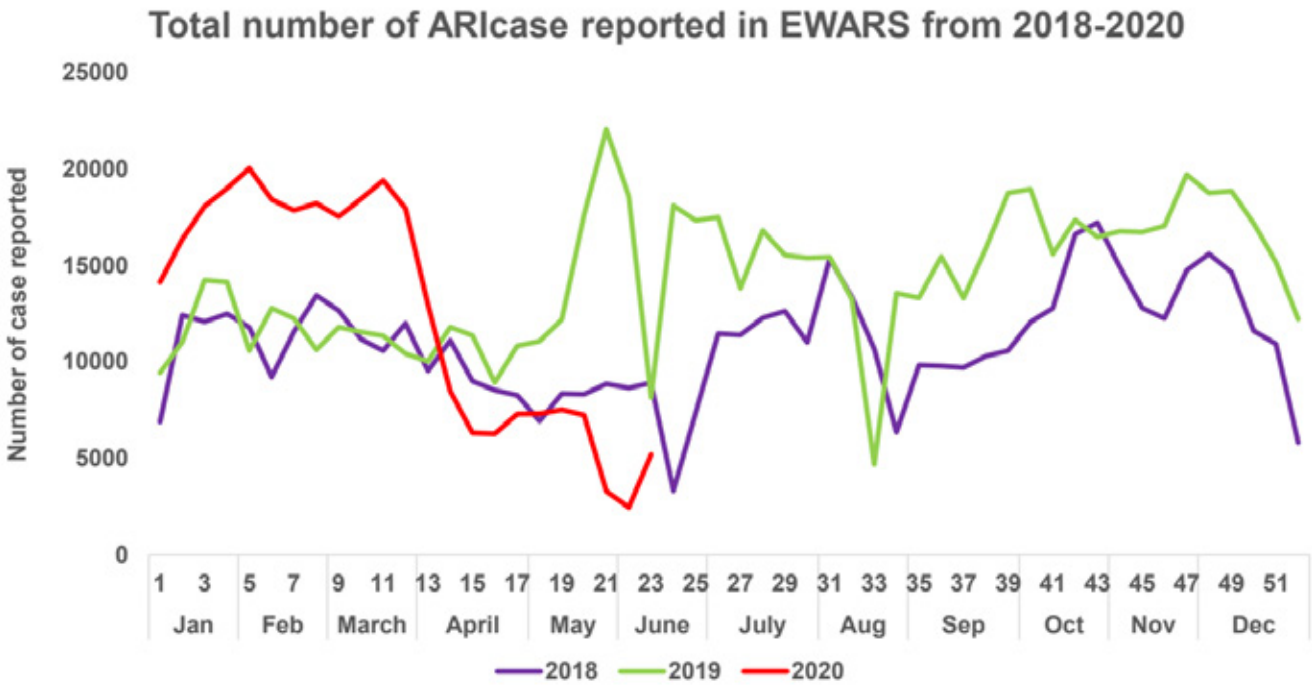
• **Reiterate that there should be no forced return of refugees.** The rights and safety of the Rohingya must be ensured before seriously considering plans for their return to Myanmar, particularly during the uncertain time of COVID-19. International law requires the return of any refugees to be voluntary. The Rohingya still do not have any level of citizenship or basic rights in Myanmar, which is a major barrier to their safe return home.



“Anxiety is increasing in both the patient population as well as the medical clinic staff. Clinic staff have expressed anxiety related to conducting triage and travelling to and from the clinic due to fear of increased risk of exposure to COVID-19.”

- Dr. Maryam Molla, former MedGlobal Field Coordinator

**ARI Update**



Source: Health Sector, June 10





# MedGlobal

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