COVID-19 and Faith in Cox's Bazar, Bangladesh

FEATURES

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REPORTAGE

How disaster and religion intertwine for those in Rohingya refugee camps

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COVID-19 IS directly impacting the most vulnerable section of society in Bangladesh—its Rohingya refugees—a community which narrowly survived genocide in their native Myanmar, now subjected to mass displacement in the region. Combined with the impact of Cyclone Amphan and Cyclone Yaas in 2020 and 2021 respectively, Bangladesh's constant battle with the climate crisis is well-documented. The mass displacement and persecution, however, continue to impact the largely overlooked refugee population.

Approximately 1.2 million Rohingya refugees have been living in the 27 camps in two sub-districts of Cox's Bazar district since 2017. Late last year, there were state-led actions that alarmed both humanitarian and human rights groups. The Government of Bangladesh, in December 2020, began moving Rohingya refugees from Cox's Bazar to Bhasan Char, a secluded island without adequate healthcare infrastructure or protection against extreme weather events like severe cyclones and tidal surges. So far, more than 20,000 people have been moved, out of the planned 100,000 refugees to the low-lying silt island.

Grappling with the effects of double displacement, initially from their home country and now being forcibly shifted from refugee camp to camp, coupled with the uncertainties about their legal status and insecurity over their future in their host country, the plight of the Rohingyas is a humanitarian crisis that shames humanity.

Faith and Health of the Rohingya Refugees

In 2020, several months of lockdown measures, put in place by the Government of Bangladesh to protect against COVID-19, led to a severe loss of livelihood for many of the country's vulnerable and poor. In Cox's Bazar, women-headed households, persons with disability, and elderly people have resorted to strategies that affect their health and well-being. Women and children are eating less nutritious foods and fewer meals in a day, reducing the quantities they eat. These harmful dietary practices are a result of their socio-economic conditions, especially loss of livelihoods and limited food relief during the COVID-19 crisis. It speaks of people on the brink, left to their own devices, and at the mercy of their faith. The Rohingya people are predominantly Muslim. Their community leaders are usually imams and muezzins leading prayers at mosques. As witnessed the world over, several COVID-19 conspiracies were at play. This emerged as the case with both Rohingya and Bengali communities, who turned to faith in trying and testing circumstances and in the face of uncertainty and scant information. These are usually the circumstances in which people who have lost all hope resort to religion. Rohingya refugees in Cox's Bazar too believed that COVID-19 was a punishment and a test of their faith. Disease and health, thus, became entwined with spirituality, religion, and other spheres of life, including financial struggle.

For this article, we interviewed imams, muezzins, women faith actors, and local NGOs who were instrumental in raising awareness on COVID-19 preventive strategies, surveying 100 households from both the Bangladeshi host populations and Rohingya refugees in Camps 15 and 19 in Cox's Bazar. At the inception of the pandemic, in the throes of fear and insecurity on the ground, there were numerous conspiracies about the government in Bangladesh, just like anywhere else in the world. During Jummahprayers, religious leaders who initially supported fatalistic notions about COVID-19 virus were encouraging people to wash their hands to maintain cleanliness, and to wear masks.

> In the face of uncertainty and scant information in the pandemic, both Rohingya and Bengali communities turned to their faith in trying and testing circumstances.

In 2020, Dhaka Ahsania Mission (DAM) set up a health outpost in Camp 19, and provided basic health services to the people living in the camps. The health staff assisted people with COVID-19-related measures and treatments. The DAM facility had referred 26 suspected cases—22 Rohingya members and 4 villagers—to the nearest hospital, where two positive cases were found amongst the Bengali villagers. The health outpost provided screenings for COVID-19 symptoms and referred them to the hospitals, while for the non-COVID-19 cases they provided treatments. As per the data provided to us by DAM, over 400 patients were treated, consisting of both Rohingya refugees and host community members. An official from DAM mentioned the following about the caseload:

"As per health data, there were 367 positive cases and 10 deaths amongst Rohingyas across 32 camps. Within Camp 19, there were five positive cases in refugees and three hospital staff tested positive. Approximately 5,000 positive cases in the host community."

This must be viewed within the larger context of limited facilities for testing within the camps in Cox's Bazar. A medical doctor noted that only 25,000 had been tested so far out of 1.2 million people as of January 2021. Specifically in Camps 15 and 19, there are no sentinel sites.

Inside a Rohingya Refugee Camp (RRC) Masjid. Courtesy of Abu Yousuf Shazid

Another NGO, Dushtha Shasthya Kendra (DSK), undertook an initiative for public health messaging, generating awareness and providing timely information and discussions with around 700 Rohingya community members. They employed an interesting approach of using public speakers and microphones in the mosques, as well as door-to-door campaigns for providing information on COVID-19 preventive measures. They provided training to community and faith leaders, dispelling some of the rumours and misinformation that were rampantly spreading in these communities.

With the collision of science and faith, there were interesting ways in which Rohingyas resisted and adapted to the new circumstances. From an outsider's perspective, it appeared that faith leaders were fatalistic, which percolated amongst other community members participating in our group discussions. Rohingya men and women were concerned that the elderly were susceptible because they did not remain "clean," presumably concerning their personal hygiene. Many people shared that initially they had lots of misinformation and misbeliefs, believing COVID-19 was an act of God to punish the non-religious. Depending on who their community leaders were, such views would be either contested or encouraged, especially during prayertime.

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There were strong associations between cleanliness and the disease. Several rumours emerged about what causes COVID-19, just as it was commonly observed in countries in the Global South as well as Global North. Qualitative data indicates people received COVID-19 information through social media, public spaces like tea stalls, religious gatherings, and meetings at mosques. While there is a strong feeling that the pandemic is religiously ordained, a significant proportion of the people still believe it to be a response to their sins; or as nature's response to man's cruelty, or even due to a lack of belief in Islam.

It is essential to note that these fatalist attitudes were the result of a combination of misinformation, manipulation, and inappropriate channels of information that the Rohingyas had limited access to. In the absence of large-scale humanitarian support, abandoned by their host and persecuted by their native country, the Rohingyas largely relied on their faith to tide over challenging circumstances. Hearing their stories about the painful and arduous journey from Rakhine state to Bangladesh, it is remarkable that these communities continue to thrive and survive in the face of challenging and dire circumstances. They relied on their community leaders, unelected Rohingya called “majhis,” for information and guidance to not only make this journey to Bangladesh but also manoeuvre the flailing political, administrative, and governance structures in the camps.

Religious actors & women leaders

With the merging of faith and public health, a key group of actors emerged as powerful and influential in changing beliefs and attitudes about COVID-19. Imams and muezzins played a crucial role in promoting healthcare in the Rohingya community, and several humanitarian NGOs relied on these religious leaders to promote preventive messages on COVID-19. Within the Bangladeshi community, the imam is a leader of the community revered for their exemplary adherence to faith. Imams in the Rohingya community play a similar role, and thus it is widely accepted that an imam’s verdict and messages about COVID-19 are sincere and trustworthy. Majhi, although originally a term used to refer to the leader who helped Rohingya refugees flee from Myanmar to Bangladesh, was also the name of the camp in-charge in Cox’s Bazar. The majhi system was initially established by

the Bangladeshi authorities to manage the influx of refugees in 2017, but over the years it became an administrative position elected without participation and representation of the Rohingya communities. In effect, majhi were no longer the traditional leaders or elders of the Rohingya communities, and they neither reflected nor represented the voices, needs, and aspirations of these displaced groups.

Several NGOs trained and addressed misconceptions held by the imams and muezzins and enlisted their support in delivering COVID-19 messaging during prayers. Interestingly, some imams married scientific facts with religious edicts. A Rohingya teacher said:

"Lots of people live here and it is difficult to manage them. If any message and information are needed to deliver to the people, the leaders act as the main role. For NGOs and other officials, it is not possible to reach all people. The leaders also discuss different issues with the officials."

Religious gatherings, especially jummah/Friday sermons called by the imam, appear to be the best source of information for the masses. A woman leader, who actively participated in the DSK NGO's training programmes, noted that every Friday at the time of prayer, the imam discussed how we could be safe from the coronavirus. However, since women do not usually go to the mosques, those who attended the training from DSK would share what they learnt with other women near their homes. She also shared that since schools were closed due to lockdown measures in 2020, they lost out on a vital and reliable source of information. They had to pay approximately 100 takas ($1) per month for school, hence many could not afford going to school.

A COVID-19 DSK awareness poster in a refugee camp. Courtesy of Abu Yousuf Shazid

There were other information sources that were reported as the highly trusted and least trusted information sources for COVID-19: radios, television, posters, billboards, social media channels, and websites. People relied on social actors from both health and religious institutions, such as community health workers, majhis, imams, madrassa teachers, traditional healers, and members of the Tablighi Jamaat. Some depended on their friends, neighbours, and community health events for health-related information. Of these, community health workers and faith leaders such as majhis, imams, and madrassa teachers emerged as the top three sources of information as reported. Imams and muezzins were considered as trustworthy by the community members.

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Rohingya members were skeptical about messages received from posters and radio as these did not explain much of the instructions they had to follow. Many times, these were in languages—English or Bengali—they were not able to read or comprehend easily.

The lack of educational and literacy programmes for Rohingya refugees is pivotal to understanding Rohingya communities. Rohingya refugees are not allowed to read and write in the local Bengali language. There are no integration programmes available for refugees in Bangladesh, particularly for the Rohingyas. Although the Rohingya language, Ruáingga, has some affinity to the Chittagonian dialect spoken in Cox's Bazar, many refugees are unable to read and write in Bengali. The refugee members have poor literacy rates due to systemic persecution and lack educational opportunities in Myanmar, and continued negligence in Bangladesh. The access to and continuation of education for Rohingya girls is very limited. Parental attitudes towards education for girls reportedly shift once girls turn ten years old as societal norms may allow girl children to be married. With limited economic means young girls are not enrolled into education programmes run by NGOs in the camps. Their educational attainment levels are well below average after having fled genocide and war in Myanmar, a symptom of the abject exclusion of the Rohingyas from education in both host and home countries.

Male teachers provided a different perspective on how religion was limited in its capacity to counter the global coronavirus pandemic. One of the teachers who was interviewed clarified that there is nothing related to COVID-19 in the Quran or Hadith, although Islam asks everyone to stay clean. He went on to reflect how teachers were "trying" to unlearn misinformation that they gathered through various mediums like social media or others. The madrassa teachers also had a role to play in the COVID-19 response. Firstly, teachers from schools or madrassas are very respected people in Rohingya society, an intellectual privilege that allows them an ease in delivering their messages. Rohingya exclusion from society, education, and other opportunities has fed into cynicism over science and outsiders, and they heavily rely on local actors and leaders whom they trust rather than external social workers. While the teachers are involved in the faith-based committee, they also have access to mobile phones which means they can access updated information. Their involvement in the training and awareness programmes has helped NGOs to build trust with refugee community members. This process has been capitalized to deliver

COVID-19 preventive messages to the people, through teachers who have a unique way of perceiving and explaining scientific ideas with religion to counter misinformation amongst the people.

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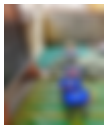
Despite religious leaders being male figures, there were local women leaders who actively participated in religious activities. Although women leaders have lesser authority than their traditional male counterparts, Rohingya women can reach out to women leaders easily. Imams and muezzins did not interact directly with women and children because their religious responsibilities were largely centred around the mosque.

An Arabic teaching room in an RRC Masjid. Courtesy of Abu Yousuf Shazid



Since women did not have access to religious and educational spaces, they were more likely to have untested misbeliefs and attitudes towards COVID-19. Some women leaders in the Rohingya communities were included in NGO training and were enlisted for house-to-house visits and providing information on COVID-19 preventive steps. However, their numbers are few—most women leaders continue to believe and share their misinformation about COVID-19. For instance, a 35-year-old female leader (name withheld) explained her understanding about the cause of COVID-19 as being an "order from God," and that we need to keep ourselves "neat and clean" in order to prevent ourselves from being infected. They have little access to information, with limited to no educational opportunities, and are unable to voice their opinions and apprehensions in relief and awareness programmes. Such misinformation is, of course, not limited to Rohingya or Bangladeshi women. In order to stop the flow, the government, humanitarian actors, and media will have to take steps to rule out every possible rumor with scientific fact. This should be accessible and available in several languages, written and orally presented widely.

This reveals the fact that women are less considered for group and organized meetings; they remain as passive receptors of information passed onto them by their husbands. This provides fertile ground for the spread of misinformation and misconceptions, often used to suppress women further in such isolating circumstances. There were physical and social barriers that determined the uptake of COVID-19 preventive messages, such as low literacy levels, cultural and linguistic differences between host and refugee communities,

and no access to basic health, educational, and livelihood opportunities. Local faith and community leaders can play a vital role in addressing vaccine hesitancy and cultural biases related to vaccine uptake amongst both Bangladeshi and Rohingya communities.

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Gender experts are also alarmed at the increased rates of domestic violence during the pandemic. There have been numerous cases of intimate partner violence against women isolated with abusive partners. Women's responsibilities and workload were overburdened as men were barred from going out during lockdown. COVID-19 has had a huge impact on women's rights and their access to justice. There are strict restrictions imposed on them, which became stricter during the pandemic: limited movement outside the home and adherence to follow instructions.

Several rumours reported by Rohingyas were shared by a senior official from DAM NGO during a telephone interview.

"Rohingya people were scared. They used to say: 'If we go to the health post, we will be sent to Bishan Char island, or we may go missing. We may even be killed."

The official interpreted these rumours as symbolic of a genuine mistrust between the health system and refugee populations. However, they reflect the harsh realities of the Rohingyas who have no one to turn to and who fear further persecution from authorities, constantly coming across government initiatives that push them further into destitution.

The Future of Humanitarianism in Cox's Bazar

No country was prepared to face such a pandemic, and yet, for persecuted communities like the Rohingyas, these uncertainties and health emergencies are symptomatic of a larger phenomenon that isolates, negates, and further reproduces the injustice and unfair

conflict that they have faced not only with the government authorities. Misinformation and mistrust is not a unique phenomenon to the Rohingyas but it is important to unpack why people are peddling conspiracy theories instead—lack of information, spread of disinformation campaigns on social media and the Internet, and politicians and society leaders questioning the severity of the pandemic while silencing the needs and voices of Rohingya refugees.

On September 29, 2021, Mohibullah, 46, chair of the Arakan Rohingya Society for Peace and Human Rights (ARSPH), was shot and killed by unidentified gunmen in Kutupalong camp in Cox's Bazar, Bangladesh. Several human rights and NGO workers have criticized this killing as not only silencing Rohingya voices, but also refusing to have a dialogue with the refugees for their safe future, either in Bangladesh or in a safe return to Myanmar. Many believe that the non-state actor Arakan Rohingya Salvation Army (ARSA), an armed group present in the camp, is responsible for this violent and gruesome murder. With disarray in camps and limited resources from humanitarian actors, violence has become rampant, resulting in murders and abductions. It is the responsibility of government authorities to ensure the protection of people in the camps, including refugees, activists, and humanitarian workers from both the Rohingya and local community, many of whom have shared concerns about their safety.

Any humanitarian effort should build on an understanding of the underlying drivers of conflict, violence, and issues affecting social cohesion within the local Bangladeshi communities in Cox's Bazar. Social cohesion factors such as a sense of social or group identity, sense of community, and attachment to place can be important adaptation drivers when considering how populations respond to public health and other crises. These factors, together with community-based leadership, including faith-based leadership, can play an important role in the development and increasing social bonds central to Rohingya capacities when confronting COVID-19 and a range of other hazards. Mapping out power relations and structures within and beyond the Rohingya community could help meaningfully engage with the persecuted minority.

The battle for citizenship and statehood for Rohingyas is long and dates to colonial history and negligence by Burmese authorities. While these groups await their uncertain future, it is the responsibility and mandate of neighbouring countries like India and Bangladesh to be proactive and participatory in their approaches to the needs of this population. While the humanitarian world debates whether Myanmar is culpable for the genocide of the Rohingyas, their day-to-day needs and lived realities can no longer be brushed under the carpet or silenced through more violence. ▢

Photograph courtesy of Abu Yousuf Shazid, depicting Dhaka Ahsania Mission (DAM) hand washing station.

Reportage

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