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Humanitarian vs Pandemic Responses: Vulnerable Groups among Rohingyas in Bangladesh*

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Abstract The Rohingya diaspora is a politically sensitive humanitarian crisis for Bangladesh. The current Covid-19 pandemic poses a range of governance, demographic, and environmental policy challenges in an already fragile context. The ongoing situation combined with the pandemic requires a rethinking of humanitarian strategies to tackle the double burden of crises – humanitarian and pandemic. Drawing together evidence and experience from a mixed method participatory action research conducted among Rohingya refugees and the host community in Bangladesh, this article highlights the importance of the institutional readiness of research organisations to produce contextual interventions and targeted approaches in pandemic and humanitarian response for diverse communities. The article also reflects on the strategies researchers applied to create a knowledge network between researchers and implementers, which not only informed the study design and its selection of most vulnerable groups but also worked towards producing knowledge fit for purpose, where critical evidence was shared with key decision makers and policymakers.

Keywords humanitarian crises, pandemic response, Bangladesh, Rohingyas, refugees, policy impact, vulnerability, complex emergencies, humanitarian health, vulnerable groups.

1 Background

Humanitarian crises are at an all-time high, with prolonged crises of great magnitudes in Syria, Yemen, South Sudan (Spiegel 2017), Türkiye, and Colombia, as well as Bangladesh. As a result, the number of forcibly displaced persons, whether internally displaced or refugees, is at its highest, estimated at 89.3 million worldwide (UNHCR 2022). Also, least developed countries (LDCs), which includes Bangladesh, host 27 per cent of all people

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displaced across borders worldwide (*ibid.*). Therefore, these humanitarian issues transcend borders and have statistical importance (Cameron 2014).

Bangladesh hosts the largest refugee population in the world in Cox's Bazar District, with 855,000 forcibly displaced Myanmar nationals, commonly known as Rohingya refugees (World Vision 2020). A majority of them have taken shelter in 34 makeshift camps in Ukhia and Teknaf subdistricts in Cox's Bazar. Women, adolescents (particularly adolescent girls), the elderly, and persons with disabilities (hereafter known as the most vulnerable groups, MVGs) are further marginalised during emergencies (MSNA Technical Working Group 2020). Around 90 per cent of them depend on humanitarian assistance from the Government of Bangladesh, United Nations (UN) agencies, and national and international non-governmental organisations (NGOs/INGOs) (*ibid.*). With any crisis management in humanitarian settings, the priority initially in these camps is to provide shelter, clean water, sanitation, and prevent serious communicable diseases (such as diarrhoea, cholera, and diphtheria) (Chan, Chiu and Chan 2018). Recently, the Covid-19 pandemic has added further complexities to the health system in the Rohingya camps, where these issues intersect with a range of pre-existing governance, demographic, and environmental policy challenges.

Despite the availability of statistics on refugees and their MVGs through assessments such as the World Food Programme's (WFP) Refugee Influx Emergency Vulnerability Assessment (REVA-5) (WFP 2022) and the Inter Sector Coordination Group's (ISCG) needs assessments for persons with disabilities and the elderly (REACH 2021), there is minimal understanding of community contexts and the diverse specific vulnerabilities which have emerged or have been exacerbated as a result of the pandemic. Humanitarian decision-making often has a standardised approach for all (Clarke and Darcy 2014) and does not always consider lived experiences, differing vulnerabilities, and those who may be at high risk within the refugee population. Policies need to be tailor-made and customised, and this requires evidence to formulate localised humanitarian responses to tackle the double burden of a pandemic and humanitarian crises for MVGs.

With an aim to provide critical evidence on on-ground realities to assist policymakers and humanitarian aid agencies in evidence-based informed decision-making, the BRAC James P Grant School of Public Health, BRAC University conducted a participatory action research project in ten Rohingya camps from August 2020 to July 2021. This research employed a mixed method approach combining participatory qualitative methods and a household survey to document the impact of the Covid-19 pandemic on MVGs, and formulated specific recommendations for humanitarian aid agencies targeting both humanitarian and pandemic responses.

This research identified MVGs among Rohingya refugees by triangulating findings from multiple methods, including a desk review, stakeholder consultation workshop and informal discussions, and interviews with a range of community participants (i.e. Rohingya refugees). This research also developed a gender-based vulnerability survey index (Nasar *et al*. 2022), using context-specific data to assess the level of vulnerability within MVGs. The research provides critical insights for designing localised targeted approaches/solutions. This article also reflects on the key lessons learnt by the researchers throughout the research process that can complement future research and strategies to influence policies and programmes. We presented the lessons as institutional readiness and knowledge fit for purpose. We recognised accomplished institutional readiness through multisector collaboration, stakeholder engagement in research, and timely sharing of research data. The characteristics that define knowledge fit for purpose are the co-production of contextual knowledge and the translation of evidence into action.

2 Institutional readiness for conducting research in a complex socio-political context during the pandemic

2.1 Multisector collaboration

The first case of the coronavirus (Covid-19) was detected in Cox's Bazar on 23 March 2020, and the first case in the camps was detected on 14 May 2020 (World Vision 2020); this increased to 130 cases (and six deaths) in the camps by the first week of September 2020 (*ibid.*). A lockdown was declared in the district, including the 34 refugee camps. The lockdown measures included a district-wide ban on travelling to and from the district, a ban on public gatherings, and reduced travel into the Rohingya camps (*Dhaka Tribune* 2020). As the Rohingya camps are densely populated, with approximately 40,000 people per sq. km (Amnesty International 2020), there was an initial fear of a massive spread of the virus within the camps. As a Covid-19 containment measure, the Refugee Relief and Repatriation Commissioner (RRRC) instructed all stakeholders/agencies to scale down humanitarian assistance to only essential lifesaving services, which included health, food, water and sanitation, nutrition, information dissemination, cooking fuel, and limited protection services (MSNA Technical Working Group 2020). The movement of aid workers was also restricted, except for essential service providers (health facilities, ration distribution centres). To support the Government of Bangladesh and in alignment with the National Response Plan, the ISCG partners (UN agencies, NGOs, and INGOs) incorporated the Covid-19 Response Plan into the Joint Response Plan 2020 for Rohingya Humanitarian Crisis (ISCG 2020).

Humanitarian systems that address complex emergencies consist of a broad and diverse range of actors, including governments, donors, multilateral and bilateral agencies, INGOs, NGOs, community-based organisations, UN agencies, and

international agencies (Spiegel 2017), and require high levels of coordination between multiple actors. In Bangladesh, both the national and Rohingya Covid-19 response plans emphasised the importance of multisector collaboration in pandemic management (Government of Bangladesh 2020; ISCG 2020) These collaborations provided critical points of access for researchers, which enabled access to communities (as with listing the MVGs and their current experiences) and also rapid evidence-based sharing between the research organisation and humanitarian actors, who wanted information on the plight of the refugees during this period.

This created a window of opportunity for researchers, including us, to conduct research on the impact of the pandemic on the Rohingya population living in the camps in Cox's Bazar. The RRRC, UN agencies, and other humanitarian actors welcomed researchers and provided the required administrative support to our research team. For example, they provided approvals for conducting the research, allowed access to camps, participated in the research design workshop, and provided constructive feedback on research tools. Additionally, they invited the research team to share evidence gathered in the regular health sector and relevant subsector meetings.

2.2 Stakeholder engagement in research

Different crises in humanitarian settings, such as the Covid-19 pandemic, present their own unique challenges, including local political influence on health systems and lack of contextual knowledge in understanding the challenges and unique needs of MVGs among refugees. Humanitarian actors generally practise standardised approaches to assist 'all refugees', without recognising the subgroups within refugee populations, who may be more vulnerable and at greater risk and who often need more support (Odlum *et al*. 2021).

Furthermore, given the struggle for the use of health-care research in decision-making by humanitarian actors and policymakers (Ward, House and Hamer 2009), the situation of the humanitarian crisis and the pandemic is prone to biases – cognitive and confirmation biases that are common in decision-making (Blanchet *et al*. 2018). Social science research is often neglected in favour of generalised survey data to inform policies and programmes, resulting in a disconnect between policy decisions and the complex, lived experiences of people and the heterogeneity that exists in these communities. This can cause inadequate decision-making, leading to gaps and sometimes a failure to address the complex and multidimensional vulnerabilities of MVGs, as more generalised protocols are favoured.

In addition, the lack of social science research, particularly the use of participatory approaches in research, often results in producing generalised data, which is useful but also leads to the absence of

rich, in-depth, nuanced insights of complex contexts (economic, sociocultural, and political) (Fussy, Obino and Rakhmani 2022), as well as how intersectional factors, such as age, gender, sex, location, disability, religion, and so forth can affect and lead to failures and/or gaps in interventions (Rashid *et al*. 2021). Therefore, the engagement of key stakeholders in evidence generation, through participatory approaches combining social science methods with surveys, is crucial for understanding the differing needs and vulnerabilities of MVGs (Singh *et al*. 2020) and designing appropriate policies and interventions. Our research team took several approaches to ensure the participation of the community members and key stakeholders working in Rohingya camps at different stages of the research process. This started with the identification of MVGs, followed by tool development through a research design workshop, participatory data collection, and real-time dissemination of research findings to key stakeholders using existing local-level communication channels, such as health sector meetings.

For example, we applied an integrative systematic approach to identify MVGs among the Rohingya refugees: a rapid literature review to identify MVGs based on research conducted in similar settings, followed by a research design workshop with key stakeholders in Cox's Bazar and, finally, incorporating the perspectives of the Rohingya community through field visits in a refugee camp and informal discussions with the people in the community. The categories of MVGs were finalised by triangulating the results of all three steps.

2.3 Timely sharing of research data: building relationships with key decision makers

With respect to epidemics and pandemics, such as Covid-19 in the context of the Rohingya crisis in Bangladesh, public health responses need to incorporate rapid, timely decisions to ensure optimal coordination and allocation of resources and interventions. Considering complex emergencies, there is a need to act quickly with limited data, further adding to the complexity (Khalid *et al*. 2020). We acknowledged the need for timely data-sharing with key decision makers. Our researchers regularly attended health sector coordination meetings and Communications with Communities (CwC) working group meetings. At these meetings, the team shared recently collected research findings with humanitarian actors responsible for humanitarian and pandemic responses to inform as well as try to align with any immediate or long-term planning.

As data was being collected and analysed at a rapid pace, given the urgency of the Covid-19 crisis and the demands from the CwC to share evidence, the meetings provided an important channel of communication between researchers and practitioners. This approach was effective in building a trusted relationship with key stakeholders and decision makers/policymakers, and creating an

enabling environment for sharing and acceptance of real-time evidence. However, for this process to be carried out effectively, it requires willingness from the implementers and their institutions, as well as the dedication of research organisations to attend meetings and engage with various stakeholders. Experiences showed that the timely sharing of evidence increases the likelihood of the uptake of research findings into action (Ellen *et al*. 2013), if not immediately, at least in the future.

3 Knowledge fit for purpose

3.1 Co-production of contextual knowledge

The Government of Bangladesh and key humanitarian actors constantly require contextually grounded plans and strategies to mitigate the impacts of the Covid-19 pandemic, particularly among MVGs. There are limited and sporadic accounts of what is happening at the ground level, given the current reliance on rapid surveys with a limited in-depth understanding of the risks created by the pandemic (Mistry *et al*. 2021; Kohrt *et al*. 2019). It was critical to document the impact of the pandemic on MVGs and the humanitarian interventions in Cox's Bazar in order to integrate and design localised humanitarian responses, which would be culturally and contextually effective and accountable. Recognising the urgency to provide evidence on the ground realities, our participatory action research aimed to co-produce contextual knowledge that could inform policymakers and humanitarian agencies about the priority areas, as well as the possibility for localised solutions for both humanitarian and pandemic responses.

The central question associated with the localisation agenda revolves around the issue of capacity and what standard of service delivery is needed to respond to humanitarian crises (Wake and Bryant 2018). As the crisis became protracted, with the added vulnerabilities created by the Covid-19 pandemic, there was a recognition that robust strategies needed to be formulated to ensure greater localisation of humanitarian and pandemic responses, inclusive of both needs-based and rights-based approaches. The co-production of contextual knowledge with the affected communities and key actors on the ground can contribute to developing localised interventions targeting specific groups of the population at risk (Vincent *et al*. 2021; Schmalenbach 2019).

After the onset of Covid-19 in Bangladesh, humanitarian aid agencies and actors developed the Covid-19 Response Plan 2020 as an Addendum to the Joint Response Plan 2020, where they identified elderly people, women, adolescent girls, and youth as the groups most affected by the pandemic (ISCG 2020). However, through the co-production methods with the Rohingya community and key stakeholders (RRRC, UN agencies, local NGOs, and researchers) in our participatory research, we found five categories of MVGs – pregnant and lactating mothers

(with children under two years old), adolescent girls and boys (age 10–19 years), elderly males and females (age >64 years), people with disabilities, and single (widow/divorced/abandoned by spouse) female household heads (HHs). This finding re-emphasised the importance of co-producing knowledge that reflects the perspectives of the affected communities and humanitarian actors who directly serve those communities.

The Covid-19 Response Plan 2020 (ISCG 2020) and the Joint Response Plan 2021 (ISCG 2021a) acknowledged the adverse impact of the pandemic on food security among poor households and outlined the plans to mitigate it. Despite the combined efforts of humanitarian actors in Cox's Bazar in Covid-19 management, humanitarian responses were severely disrupted by Covid-19 containment measures. As our research findings reveal, Rohingya refugees, especially the MVGs (such as female-headed households, elderly people, and people with disabilities), who are mostly dependent on relief, suffered the most (BRAC JPGSPH 2021b; MSNA Technical Working Group 2020).

For instance, our research also found that the food supply chain in the camps had broken down because of the lockdown. The Joint Multi-Sector Needs Assessment (*ibid.*) reported that the supplementary feeding programme for pregnant and lactating mothers and children worsened during the lockdown because of human resource reduction in food distribution centres, resulting in less food consumption (*ibid.*). The WFP reduced the frequency of food distribution to minimise the risk of infection and also limited the diversity of food in the food package (*ibid.*). This not only resulted in inadequate food supplies but also the quality of food distributed among the refugees, especially during the lockdown. Our female research participants complained about receiving inadequate food rations containing rotten food. The food ration consisted of mostly dry food (rice, lentils, onions, cooking oils), but not meat, fish, eggs, or vegetables. One of the female HH participants (30-year-old, single HH) shared: 'We got rotten fish and potatoes. How can we eat those? Sometimes they did not give us onions. And the rice was not enough for the whole family. Then how can we eat properly?'

Furthermore, the Covid-19 containment measures, particularly mobility restriction, stay-at-home instructions, and strict physical distancing rules in the relief distribution centres and health-care facilities, had significant effects on elderly people and people with disabilities. Although the Covid-19 Response Plan for Rohingyas emphasised prioritising marginalised groups such as elderly people and people with disabilities in food and relief distributions and providing food at their doorsteps if needed (BRAC JPGSPH 2021b; ISCG 2021b; MSNA Technical Working Group 2020), our research participants shared their struggles in collecting food rations during the lockdown.

The movement restrictions of the pandemic policy coupled with gendered norms of mobility restrictions for Rohingya women magnified the struggles of women without husbands or sons (who can assist with family responsibilities) and female-headed households. Cultural and religious norms dictate that Rohingya women are not allowed to move outside the home without being accompanied by a male household member. Therefore, Rohingya refugee women living alone or without male family members usually depended on male relatives/neighbours to assist them to collect relief materials and rations from distribution centres, as well as to buy food or daily necessities from local markets. However, despite the protocols for food distribution and rations, these Rohingya women were unable to utilise these services, further deepening their existing vulnerabilities.

These insights demonstrate that despite the protocols in place to attend to emergencies such as the Covid-19 pandemic, understanding the day-to-day implementation process is key to identifying implementation gaps and challenges. This also further highlights the importance of contextual knowledge of the ground realities that can assist humanitarian aid agencies in taking measures to address those gaps.

3.2 Translation of evidence into action

This research generated evidence in several key areas and evidence-based recommendations were formulated to support the Covid-19 response and recovery plan for the Rohingya community. It was evident from the research findings that there was some obscurity in the Covid-19 messaging which created misconceptions, fear, rumours, and stigma among people in the community. Considering the misconceptions surrounding the Covid-19 virus and its subsequent impacts, it is important to disseminate culturally appropriate messaging and consider the perspectives of the communities to address local social, religious, and other concerns regarding Covid-19.

By considering community perspectives, we worked closely with an implementation partner, the Centre for Peace and Justice (CPJ), BRAC University. As research data was being analysed, the findings were shared with the CPJ, allowing them to develop community-based Covid-19 awareness interventions focusing on risk communication. Locally recruited and trained Rohingya youth volunteers disseminated Covid-19 awareness messages among 2,974 Rohingyas through community outreach workshops. The CPJ's experience of conducting community outreach workshops also generated important evidence for humanitarian actors to consider while designing interventions for Covid-19 response and recovery for the Rohingya community.

Guided by the research findings about the community's trusted personnel for information dissemination, youth volunteers engaged community leaders/block Majhis[5] and other influential

people for information dissemination, especially among elderly people. The CPJ developed a pictorial booklet for people with disabilities, focusing on those who have hearing or speech impairments. Youth volunteers used this pictorial booklet in awareness sessions with people with disabilities and sometimes they tried to convey messages by drawing the information on paper. They engaged caregivers in the sessions, so that the caregivers could help participants with disabilities understand and follow Covid-19 safety measures. All of these learnings and experiences indicate that a uniform blanket approach is not suitable across groups. Awareness building/information dissemination interventions require customisation according to the type of participant.

In addition, another significant output and contribution of this research project was the research team conducting a rapid assessment and situation analysis of the fire incident that occurred in the Rohingya refugee camps in March 2021 (BRAC JPGSPH 2021a) as a response to the request from the ISCG for developing a joint action plan for post-fire response at the camps. Based on the research findings, the research team formulated crucial recommendations and shared them with the relevant subsectors and working groups. The research team, as a knowledge partner, supported the health sector in identifying better solutions for the affected community (*ibid*.).

4 Lessons learnt and reflections

Uncertain and complex situations often lead humanitarian actors to rely on heuristic forms of thinking (Comes 2016; Blanchet *et al*. 2018), which can lead to biases. Therefore, it is important to ask what determines the institutional readiness of researchers and what constitutes knowledge fit for purpose in humanitarian crises such as the Rohingya refugee crisis in Bangladesh. Over recent years, there has been an increase in rapid evidence summaries in the humanitarian aid sector which present information in a non-technical manner (Allen 2014; Clarke and Darcy 2014; Mahapatra 2014). However, rapid evidence may not always be applicable and synthesised in time for every context. In addition, synthesised and quantitative data cannot describe the on-ground realities of the affected populations (Colombo and Checchi 2018).

Rapid tools such as the Humanitarian Emergency Settings Perceived Needs Scale (HESPER) developed by the World Health Organization (WHO) and King's College London provide a quick and scientific method for assessing the serious perceived needs of people in humanitarian crises (WHO and King's College London 2011). However, even the use of these tools requires expertise in survey management, access to individuals/households, and statistical expertise to apply and analyse the tool, as well as funds to deploy surveyors (*ibid*.).

The lessons learnt from our research in the Rohingya camps suggest that the key characteristics of useful knowledge need to rely on an in-depth understanding of ground-level issues, understanding service delivery from the recipient's point of view, the usability of the research, and the integration of community perspectives. This can be achieved through the application of social science research methodologies. Such methods can be adapted and sensitive to local contexts. In this case, MVGs in our research were found to have faced unique challenges such as Covid-19 misinformation, food insecurity, disrupted economic opportunities, and inadequacies with food rations during and before the lockdown.

From our research, we learnt that for knowledge to be positioned effectively to resolve ground-level issues it required the institutional readiness of the research organisation: engaging in multisector collaboration, stakeholder participation in research, and the timely sharing of research data by researchers. This was achieved through the engagement of stakeholders within the research design, as with our tool development and participatory study design. Furthermore, linking with an implementation partner or partners can fast-track the application of research findings towards contextualised interventions. This addresses the element of collecting contextual public health information (Colombo and Checchi 2018).

Also, the sharing of research data during the research phase not only provided timely information to practitioners for decision-making but also integrated researchers within regular formal stakeholder meetings, enabling research to target all parts of the decision-making process (Barends, Rosseau and Briner 2014). This can assist in providing evidence and has the potential to reduce the gaps in present and future policy/implementation initiatives. It also creates a trust-based network of researchers, practitioners, and policymakers – which has seen some success in a maternal health initiative in the Indian state of Karnataka (Sen *et al*. 2017) – enabling knowledge mobilisation at the humanitarian level. This was further evidenced by our rapid research assessment of the fire in the Rohingya camps (BRAC JPGSPH 2021a), where rapid research was made possible through our implementation partner's outreach, and the contextual findings were disseminated to practitioners within the ISCG to inform their emergency interventions.

Regardless of institutional readiness and relevant knowledge production, the application of research findings in interventions is still subject to factors involving political will, organisational considerations, and ethical dilemmas (Gotowiec and Cantor-Graae 2017). Stakeholders' subjective convictions can still override the decision-making process, causing inaction (Colombo and Checchi 2018; Maxwell *et al*. 2014). An example of this was the food distribution system in the Rohingya camps,

which continued to be inefficient as it did not address the needs of specific groups. However, in spite of these factors, our participatory research within the Rohingya camps has shown that the state remains committed to providing for refugees, and any gaps can be minimised through the process of integrating researchers, practitioners, and policymakers, whereby research can reach the different levels of decision-making. This provides scope for rapid knowledge mobilisation in humanitarian settings, which can lead to faster decision-making and more locally appropriate interventions, addressing the needs of neglected/most vulnerable populations.

5 Conclusion

Our research experiences have established the importance of multisector coordination, stakeholder participation, timely data collection, and the generation of relevant contextual knowledge through research and the establishment of research-based networks. It should be acknowledged that Bangladesh is one of the few countries globally that has taken in refugees, despite its own resource constraints. The pandemic created massive panic in countries and often intensified vulnerabilities on top of pre-existing ones in fragile humanitarian settings. Public health emergency management in a humanitarian context requires coordination and collaboration for multiple sectors and a coordinated, comprehensive response plan involving both humanitarian and public health actors and researchers.

Evidence is critical and we argue that it is imperative to include all kinds of research methods to influence and inform policymakers. An intersectional analysis of sociocultural and contextual determinants, using social science methodologies, will also allow for the sensitisation of policymakers to the differential impacts and needs on the ground. If there are generalised approaches during a pandemic and poorer communities, for example, refugees, are all boxed into one category, there is a disconnect and an urgent need missed to look at more customised relief approaches for those who remain on the fringes due to their age, sex, disability, gender, religion, and so forth. Humanitarian and pandemic responses often take blanket approaches, which can render invisible the experiences of MVGs, such as pregnant women, female-headed households, elderly people, and people with disabilities.

While acknowledging the complexities of such settings is required, changing the context is not possible. However, the development of emergent solutions, such as the building of knowledge networks and partnerships across sectors, researchers, implementers, local NGOs, government actors, and agencies, as highlighted by our research, can work towards positioning knowledge at key points of decision-making and policy. This requires that research organisations practise institutional readiness through the engagement of multiple stakeholders and

their involvement in research. This has the potential to create a more efficient system to produce knowledge that is relevant and contextual and which can be incorporated into interventions that address the vulnerabilities of different groups.

Notes

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5 Designated head of block for a camp.

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