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Psychosocial Challenges of Rohingya Women in Refugee Camps during Covid 19 Lockdown

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Abstract
This paper described how Forcedly Displaced Myanmar Nationals (FDMN) Rohingya women and girls coped with difficulties during the pandemic in Cox's Bazar refugee camps. The purpose of this study is to assess the ongoing issues, coping mechanisms, and psychosocial conditions during the pandemic. This research used Focus Group Discussions (FGD) and in-depth interview, the researcher's own observation, as well as secondary data sources. The findings suggested that FDMN women faced tremendous difficulties due to a lack of food/non-food item (NFI) and unusable facilities. Despite humanitarian organizations providing extensive psychosocial support to FDMN women and girls through friendly spaces for women and girls and they volunteered in the absence of employees due to lockdown, the women faced issues related to the expectation based on their traditional role. This paper concluded that activities that can improve the psychosocial health as well as intervention for the community and increased women and girls' engagement for empowerment in decision making about their role as a woman in order to reduce their vulnerabilities to domestic violence is important. Also, FDMN men and boys should be exposed to awareness program to prevent gender-based violence.
Keywords: Rohingya Women, Gender Gap, Covid-19, Forcedly Displaced Myanmar Nationals

Introduction

Forcibly Displaced Myanmar Nationals (FDMN)/Rohingya, a predominantly Muslim ethnic minority in Myanmar's Buddhist-majority Rakhine state, have long faced persecution in a country that neither recognizes nor wants them. Despite having lived in Myanmar for many generations, they are till date classified as illegal immigrants. Since this Myanmar government denied them citizenship, the Rohingya have been subjected to a systematic campaign of violence for decades (Matthew Smith and Amy Smith, 2017). Due to the Myanmar government's failure to formally recognize them, the FDMN population has historically been understudied and undervalued, resulting in their exclusion from national censuses (Mahmood 2017; Myanmar Population and Housing census, 2014). The male-dominated Rohingya ethnic minority differs from Myanmar's dominant Buddhist group in terms of language, appearance, and religion. As a result, the Rohingya refugees are already severely disadvantaged, stateless, landless, and without the means or opportunities to live

independently. They have been fleeing to Bangladesh since the 1960s, facing oppression in Myanmar from both the government and the local population. Since August 2017, an estimated 745,000 Rohingya refugees have arrived in Cox's Bazar, Bangladesh, bringing the total number of refugees to 914,998, making it the world's largest refugee camp (RRRC-UNHCR family counting). 54 percent of newly arrived Rohingya refugees were children, 60 percent were women and girls, and 10 percent were pregnant or lactating mothers (UNICEF, 2018). Many of them were subjected to widespread and severe forms of sexual violence in Myanmar before, during, and after their migration to Bangladesh. According to Olivia Devi (2019), The vast majority of Rohingya refugees in camps in Bangladesh are unregistered. The Rohingya refugees are denied certain rights guaranteed by the 1951 Refugee Convention because Bangladesh is not a signatory to the Convention. As a result, the vast majority of unregistered refugee children only receive informal education from non-governmental organizations (NGOs). Among other refugees, the ethnic minority of Cultural Rohingya lived in a patriarchal society with limited access to information, health care, and freedom of movement for women. As a result of patriarchal hierarchies and gender ideologies of male dominance and privilege, women and girls have little control over their lives. Many gender-based programs were disrupted during the pandemic, making Rohingya women more vulnerable than ever. The deadly COVID-19 pandemic, also known as the coronavirus, is an ongoing global crisis caused by the coronavirus 2 (SARS-CoV-2) of severe acute respiratory syndrome and has affected the residents in Coxbazar. The virus was discovered in Wuhan, China, in December 2019. On 30 January 2020, the World Health Organization declared COVID-19 a Public Health Emergency of International Concern, and on 11 March 2020, it declared a pandemic. In March 2020, the virus was confirmed to have spread to Bangladesh. The country's epidemiology institute, IEDCR, reported the first three known cases on March 8, 2020. Since then, the pandemic has spread across the entire country, with the number of people affected growing by the day (Wikipedia update). A few months after the first cases were reported in Cox’s Bazar refugee camps, serious doubts about the camps' ability to isolate and test Rohingya refugees remain. As a result, the purpose of this article was to discuss the psychosocial condition, coping mechanisms, and impact of the pandemic among FDMN/Rohingya women and girls in refugee camps in Cox’s Bazar. Rohingya women, living within the context of a male dominated society even while they are in Myanmar, now have to cope with the gender issues in the refugee camps, despite being a displaced community. Therefore, what is the current state of their psychosocial health and how did the women and girls cope?

Literature Review

Psychological Empowerment of Rohingya Women

Rohingya women, in general, are faced with lack of power to make decisions in many aspects of their lives due to the male domination in decision making ie patriarchal society they lived in. The gender inequality due to cultural and traditional values left the women with very little power in decision making. Hence, the lack of empowerment in decision making may have negative impacts on their psychological wellbeing. Psychological empowerment can be defined as the psychological aspects of processes that enable people to gain greater control over their lives, become more involved in their communities, and develop critical understandings of their sociopolitical environments. (Perkins et al., 1995). The authors also defined psychological empowerment (PE) as a mechanism by which individuals gain greater control over their lives, participate in democratic decision-making processes, and develop

critical awareness of their social and political environments. Refugees with substantial social resources and strong family ties have lower levels of depression and anxiety; additionally, ethnic identity and a sense of community may be predictors of psychosocial health and wellbeing (Fenta, et al., 2004; Schweitzer, et al., 2006; Vromans, et al., 2012). Women, minorities, the poor, and the young are the most vulnerable and insecure members of society, experiencing the greatest vulnerability and insecurity in their community contexts. Women are especially vulnerable to the development of physical and psychosocial issues, which are exacerbated by illiteracy, a lack of knowledge about health care, and social isolation (Murray, et al., 2013). Christen (2012) reported that Psychological empowerment can thus be defined as the growing cognitive, emotional, behavioral, and relational capacities that individuals can develop as they participate in empowering community settings, particularly efforts to change social and political systems. This means that an empowered individual is able to make wise decisions regarding their life and the society they lived in. Unfortunately, this may not be so in the context of Rohingya women, more so, when they are in a position of being in refugee camps where their lives are managed by the male head of households and volunteer organisations that assist the refugees in the camps. Hence, lack of empowerment in decision making may affect the women's psychosocial wellbeing especially within the context of being in a refugee camp with lack of space and control over their domestic lives.

Since August 2017, Bangladesh has been providing shelter to the Forcibly Displaced Myanmar Nationals (FDMN), and, at this point, according to the UNHCR (2020), around one million are living in the refugee camps of Ukhiya, Cox's Bazar. Fortify Rights conducted participatory action research in March 2018 to November 2020 which entitled -- The Torture in My Mind: The Right to Mental Health for FDMNs Survivors of Genocide in Myanmar and Bangladesh, established that 88.7% of FDMNs experienced symptoms of depression, 84% experienced symptoms of emotional distress, and 61.2% experienced symptoms of post-traumatic stress disorder. The FDMNs crisis was referred to as massive and insurmountable which was largely overlooked. The study indicated that some 86.2% FDMNs experienced the murder of an extended family member or friend by [Myanmar] security forces, 70.6% experienced the death of family members or friends while fleeing or hiding and 29.5% experienced the murder of an immediate family member. The study discovered that 91.3 percent of FDMNs in Bangladesh face some level of difficulty carrying out common daily activities, such as maintaining basic hygiene, engaging in social or religious activities, or performing other daily tasks, as a result of the trauma they experienced. Sixty-two percent of those who reported functioning difficulties blamed them on their poor mental health. The FDMNs have been exposed to traumatic war-related events such as property destruction and loss, loss of family members, and witnessing extreme violence and injury. These events have the potential to cause them to experience a variety of psychological distress. The high number of reported mental health cases among the FDMNs population correlates with psychological distress (Jarder et al., 2020)

UN Women (2019) that in Bangladeshi refugee camps, 52 percent of Rohingya refugees are women and girls. Before and during their ordeal in Bangladesh, many of them were subjected to widespread and severe forms of sexual violence in Myanmar. They are still at a disproportionate risk of GBV after displacement, including domestic and intimate partner violence, forced marriage, exploitation, and trafficking. Half of the refugee, stateless and

internally displaced persons throughout the world are women and girls. Unaccompanied, pregnant, household leaders, physically or mentally disabled people and seniors are generally more vulnerable among refugees (UN women, 2019; Tay et al., (2018;2019). Marginality and mental health are linked in ways that go beyond race, gender, and socioeconomic status (Christens et al., 2012). According to Akter and Akter (2020), Bangladesh, like many other countries around the world, has faced numerous social and economic challenges as a result of the pandemic. These challenges for women include an increase in gender-based violence. While highlighting the pandemic's mental health implications, a recent survey conducted by the Bangladesh-based human rights organization Manusher Jonno Foundation (MJF) found that at least 4,249 women and 456 children were subjected to domestic violence in 27 out of 64 districts of Bangladesh in April 2020 alone, with 1,672 women and 424 children experiencing violence for the first time in their lives.

Methodology

This research utilized Focus Group Discussion (FGD) and in-depth interviews with selected women as methods to gather data on the psychosocial conditions, challenges, and coping mechanisms of FDMN women in refugee camps during the Pandemic. The data collection by the researcher was done with the assistance of the NGO where the researcher was involved in as a volunteer. Three FGDs were conducted, 30 FDMN adult women and adolescent girls (aged 15-45) from camps 4 (Balukhali) and 15 (Palongkhali), Ukhiya, Cos's Bazar participated. Seven women were interviewed, including Community Health Workers (CHW), health and professionals/experts from humanitarian organizations. The interviews were conducted by phone by the researcher, and group discussion sessions were conducted using guided questions in the camps. The sessions and individual interviews continued until the data was saturated. FGDs were held in Women Friendly Spaces (WFS) in specific camps to ensure the safety and confidentiality of FDMN women and girls. Respondents were chosen using convenience sampling methods based on their participation in health care service provided by the NGOs in their programmes. The researcher facilitated the sessions and interviews, as well as taking notes during the sessions and interviews.

Data Analysis

In terms of qualitative data, an inductive exploratory approach applied. Transcripts of open-ended narrative responses regarding practices and views of the Rohingya refugee women's psychosocial experiences during Covid-19 were analyzed. Responses to semi-structured interviews were reviewed for themes and patterns to gain insight regarding the women's lived experience. The facilitator/researcher read the notes and interview transcripts several times to gain a correct and deep perception. Using previous studies, the researcher observes similar themes from published materials to ensure consistency in the findings. Humanitarian organizations' emergency update reports, annual reports (2020), daily Corona update news from local newspapers, and other relevant Rohingya crisis documents have been reviewed from the internet and personal collection. In this study, the researcher also used observation by directly engaging with the community in camps in Cos's Bazar, Bangladesh.

Results

The information gathered from Focus Group Discussions and in-depth interviews was analysed in order to assess the psychosocial challenges and coping mechanisms of FDMN women living in refugee camps in Cos's Bazar.

Challenges Faced by FDMN Women and Girls due to Pandemic

22 of 30 group participants reported an increase in intimate partner violence (IPV), gender-based violence (GBV), child marriage, and dowry practice in camps during lockdown. To avoid virus spread, service providers limited their services to refugees, and as a result, domestic violence is common among FDMN families for minor reasons, most notably for food, clothing, and basic necessities. Almost all key informants stated that Rohingya men easily practice autocratic rule over their wives during the lockdown because they are sitting idly all day long and staying in a small room together with a large family. Women are stressed and bored in the family because they have to cook three times as much food for their children and family members with limited resources and food items. As a result, Rohingya husband and wife lost patience dealing with each other's daily problems as a result of poverty and a crowded living situation. Adolescent girl participants expressed their difficulties in finding a groom for them because learning centres have been closed for the past year and the girls have been staying at home. There is no place for them other than the accommodation as an outlet for other activities. A girl undergoing puberty is more of a burden for the FDMN family than a boy because the boy can roam outside the room, whereas the room is very small for 1-8 family members. Thus, the family wishes for the girl's early marriage and relocation to the groom's family in order to accommodate and share more food among family members. Three of the seven key informants provided an example of the current FDMN camp situation involving camp Majhi's (community leader's) arbitrary system during Covid-19 (lockdown), Majhis are acting as community agents, and they are disregarding the camp authority's recent ban on dowry and child marriage. Separations, verbal divorce, and domestic violence are also on the rise in camps due to a lack of camp authority and human rights organization staff.

Secondly, during the pandemic, shifting to Bhashan chor (another camp) was discussed in sessions, which is another challenge for FDMN women in camps. Few female participants claimed that their husbands were ordered by camp authorities to relocate to Bhashan chor while husband make the decisions by themselves without consulting their families or wives. A group of Rohingya men transported another Rohingya woman from the camp to Bhashan chor for marriage. One post-natal mother (participant) stated that her husband took one son out of five children without her knowledge or consent to Bhashan chor. She also learned that her husband had married a lady in Bhashan chor. Both key informants and group participants expressed their opinions about activities in camp, such as FDMN children are unlikely to return to their lessons and centers without any campaign after their learning centers reopened following the pandemic. There is a widespread crisis of basic necessities, including nonfood items (NFI) and commodities, among FDMN families, as a result, the number of sneaky thieves growing every day. Wash facilities in camps are overburdened due to a lack of regular maintenance and volunteer repair services. The water points are not working properly, and the toilets are overflowing and most of them are broken. Women and girls are walking a long distance to find suitable latrines and bathroom for hygiene. As a result, girls are subjected to eve-teasing and harassment for using sanitation facilities away from their home.

Coping Mechanism of FDMN Women During Pandemic

Community participation program is about gathering different views from whoever wants to participate and making people in the area feel welcome to voice their opinions. Some women

volunteered their services through the NGOs to assist others. Two-thirds of the group (20) volunteered at the Women Friendly Spaces (WFS) and Girl Friendly Spaces (GFS) to continue caring for women and girls in camps. Participants enthusiastically assisted the service provider organizations in carrying out the daily activities of the centers despite the presence of a limited number of employees due to the lockdown. The FDMN volunteers enjoyed their time at the centres, since their accommodation in camps are very crowded and have no ventilation since they have more space at the WFS and GFS. The volunteer women and girls invited their coworkers and neighbors (women and girls) to the center to enjoy the various life skill activities provided by the organization. FDMN women were able to relax in the center because there were Wash facilities, a prayer arrangement, and open space for resting. During the session, participants expressed their gratitude to the center employees for providing them with an alternative opportunity to stay out of the house during the day, as most of them were bored at home with family members during pandemic., considering that the men are free to go to a nearby tea shop and sit under a tree outside their home, whereas women and girls are not permitted to do so. As a result, the WFS and GFS provided safe spaces for women and girls to spend their time. The WFS and GFS provide sexually reproductive health and midwifery services, as well as safe drinking water and a play area for children under the age of five.

The camps have been under lockdown since March 14, 2020, with the exception of a small number of service providers providing emergency health care, commodity supply, and Wash facilities. According to community health workers, thousands of FDMN women and girls are denied access to WFS and GFS because of their conservativeness and cultural constraints, and they are still unfamiliar with the centers' wellness services. They are subjected to the potential dangers of daily life at home and alone. Majhi's are sometimes involved in resolving family conflicts and domestic violence. The WFS's provided activities like cooking activity which is supported by an NGO (IRC). The women cook traditional dishes and share them with the members of their communities. Handicraft activities such as painting, dying, tailoring, and embroidery are available in the centers where the women and girls are trained and put their skills to use on a daily basis. Furthermore, the women participants and volunteers were also educated on health protection activities in which they are learning about hygiene, including menstruation and personal hygiene, GBV issues, Human rights, child marriage, dowry, and other topics in order to increase their social protection as part of the care plan strategy in the centers, according to a public social servive (PSS) worker during an interview. During a crisis (lockdown) at home, the women in the FDMN group said they relieved their mental stress by reciting the Quran. They would rather recite the Quran and perform additional prayers at home, especially during a pandemic, while NGOs and organizations reduced their activities and engagement in camps.

Impact of Pandemic among FDMN Community in Camps

Community participation or public participation is the term which is used interchangeably but aims at involving people in the community to get the maximum benefit for the whole society. According to key informants and group participants, FDMN lives in camps are more difficult than ever before due to movement restrictions caused by lockdown. During Covid-19, the FDMN's movement outside the camp was strictly restricted for any reason. As a result, Rohingya men are not permitted to leave camp to perform any day labor work during the pandemic, increasing their family's vulnerability in terms of poverty. Due to a lack of

items, Rohingya women, particularly mothers and adolescent girls, who are primarily distributing food and other commodities among family members, are ignoring their own health during distribution process. In terms of education, non-formal schools and learning centers have been closed since the pandemic began, and school-age children spend their days playing outside and wasting time without learning. Two-thirds of the FGD participants observed that many adolescent girl's parents are looking for grooms for their puberty girls in order to reduce family burden while the family is facing a food and living space crisis.

Before COVID-19, all 30 FDMN participants reported having adolescent girls aged 10-18 years in their households who regularly attended learning centres or primary school. School attendance of adolescent girls was observed to be reduced during Covid-19. However, due to the Covid-19 pandemic, a number of adolescents were not consistently attending schools/learning centres due to the closure of some educational establishments. As a result, adolescent girls are unlikely to return to school following the pandemic. Gender-based violence (GBV), intimate partner violence (IPV), and divorce are all examples of gender-based violence, divorce and separation have increased during lockdown as a result of a lack of organizational support for case management among FDMN in camps. Victims are negotiating their conflict or trouble on their own, and in some cases, local Majhis are assisting them in resolving their domestic conflict verbally without any documentation. There are fewer staff and authority on duty for pandemic-related developmental interventions such as Wash infrastructure building, education programs, and skill training programs in camps. Participants and key informants predicted that the post-pandemic community would take longer to recover from the negative effects. All 30 FGD participants raised the problems of Wash facilities situation in their blocks, where many latrines are overflowing, and bathrooms and water points are broken. There are no volunteers to repair or maintain the latrines or water points due to pandemic. According to a woman interviewed, there were skepticism by some of the men where they frequently claim that" *there is no such thing as a corona in the world and that Allah will protect us from all harm**".*** These views disregarded the importance of social distancing and personal hygiene in preventing the spread of the disease.

Despite the constraints faced by the NGOs, during the pandemic, humanitarian organizations have been serving the majority of emergency activities, such as emergency health care services such as Covid tests, pandemic awareness, and law and order related tasks such as ensuring camp security. Few donors or funders have visited Rohingya refugee programs in Cox's Bazar, which may have a further budgetary impact or financial crisis for the refugee program. Furthermore, the FDMN community has lost trust and confidence in the host community and service providers due to a lack of physical presence, and regular activities in camp have ceased. They consider themselves to be the most neglected and overlooked in terms of proper treatment and vaccination, and they are given less priority because of their minority and refugee status. One Focus Group Discussion (FGD) participant expressed her outburst, and other participants agreed, saying, "*We (Rohingya people) are the most neglected people on the planet, and if we die, no one will care about us."* The status of pandemic during study period (21 May 2021) are as follows:

- Total 13 FDMN death cases reported till 21 May 2021 due to Covid-19 in 34 FDMN camps, Cox's Bazar.
- The infection has been again raising among FDMNs after few months in May 2021

- As of 21 May, total 913 FDMN detected positive out of 41477 tested cases. The positive Covid 19 cases have been increasing last two weeks in camps.
- Death rate comparing infection is 1.12% among FDMN

Discussion

According to Itzhaky and Schwartz (1998), women's empowerment is all about equipping and allowing women to make life-determining decisions through the different problems in society. The principle of Community participation holds that those who are affected by a decision have a right to be involved in the decision-making process. Alternatively, it is the process for women to redefine gender roles that allows them to acquire the ability to choose between known alternatives who have otherwise been restricted from such an ability. Despite the problems the women experienced in the camps, some of them did participate in the activities, albeit lack of support from the men. Living within a male dominated patriarchal society means that the women have to encounter many restrictions to participate and eventually empower them to make decisions that are good for their psychosocial health.

Sexual and gender-based violence has long been a problem in Cox's Bazar's Rohingya camps. The lockdown is exacerbating these issues by forcing the closure of child and women-friendly spaces. Women's rights activists inside the camps, like those in other countries, have reported an increase in domestic violence and sexual abuse. According to Akter and Akter (2020), Bangladesh is a developing country with extreme poverty, and many poor families have been impacted further by this epidemic. Healthcare, including mental health, continues to have an impact on citizens, with women and children bearing the brunt of the burden. As in many other developing countries, help and assistance are urgently needed for all citizens, particularly women in Bangladesh. Not only Bangladeshi women, but also minority Rohingya women in refugee camps, have faced difficulties. Because of the limited presence of UN and NGO bodies during the COVID-19 outbreak, the lives of the women in these camps have become more difficult (Akter & Akter, 2020). Communication barriers make it difficult for aid providers to coordinate responses and protect victims of such aggression. Aside from that, as tensions, fear, and desperation rise within Rohingya refugee and displacement camps, the Rohingya are becoming increasingly vulnerable to human trafficking.

During the first year of the pandemic, it was reported and broadcast on television that dozens of boats carrying hundreds of Rohingya people became stranded at sea. According to Quinley (2020), 59 percent of those smuggled are women and girls, many of whom are likely to be married off to men across the region. Despite the odds of having to face the extreme difficulties in the camps, the women try to adapt to the situation within limited resources, but the situation is taking a toll on their psychosocial health especially balancing between their roles as home makers in the makeshift accommodation and having a voice over what are important in their lives like personal hygiene and sexual reproductive health. However, some actions have been taken to alleviate the problems like:

- Thermal screening and hand washing points at the entry of each camp were placed. The testing capacity for COVID-19 was increased in Cox’s Bazar with the help of the United Nations and other aid agencies
- In collaboration between WHO and the Government of Bangladesh, educating the population on COVID-19 via community health workers, information service centers

located in the camps, and announcements through loudspeakers and megaphones, a laborious, time-consuming, despite sometimes, ineffective action.

- Seven active severe acute respiratory illness isolation treatment centers (SARI ITCs) with 292 SARI and 108 isolation beds are ready to serve both Rohingya refugees and adjacent host communities (Barua, et al., 2020)
- The WASH Sector has installed 2600 hand washing locations in the communities and at the household level. All refugees were supplied with soaps and stocked for up to 6 weeks.
- According to UNHCR (2020), approximately 1500 hygiene promoters worked to send key hygiene messages on COVID-19 to 35,000 households per week.
- Save the Children International (SCI) currently operates one Primary Health Care Centre (PHCC),

Conclusion

Despite widespread awareness of the Coronavirus's spread, FDMN in camps do not always practicing social distancing and personal hygiene. Humanitarian organizations are emphasizing the FDMN women and girls' participation in voluntary work in order to increase their mobility, and activities are being carried out in the absence of staff in the centers to maintain psychosocial health. This will ensure that the women and girls have other activities in the camps other than their domestic roles. Furthermore, the FDMN has been relocated to the border country of Bangladesh, and three years into their exodus, no agreement on their peaceful repatriation to their homeland has been reached. As a result, refugees are not only facing a crisis as a result of pandemics, but they are also experiencing severe traumatic situations in the camps, such as the uncertainty of statelessness. The findings of this study also revealed that women and girls are looking forward to a tunnel to see the sunlight through the Women Friendly Spaces and Women Leading Centers while coping with undocumented violence and discrimination at home during Covid-19 and lockdown. To summarize, it is suggested that decentralized psychosocial activities intervention be planned, as well as increased engagement of women and girls in activities that can educate them to raise their level of empowerment in decision making. As a result, women who stay at home can assist those who are unable to attend the centers for their household chores and relieve them of the domestic responsibilities. This is important to ensure that the women know that they have support from other women in the refugee camps.

Secondly, men and boys must be educated about the importance of preventing Gender-Based Violence, Intimate Partner Violence, child marriage, and dowry, as well as strategically planning for case management and the protection of women and girls from all forms of violence. While the education of these issues may be very difficult to be implemented while living as a displaced community, continuous effort to educate men on gender roles must be continued. This can, at least provide the women with some solace that their role in the refugee camps are worthy to be appreciated despite the constraint they faced in making lives bearable at the camps. It is important to examine the psychosocial health of the FDMN women to ensure that women will not be abused and become victims of a gender-biased community to ensure sustainability of the family institution even among displaced communities.

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