



**BBC**  
**MEDIA ACTION**

TRANSFORMING LIVES THROUGH MEDIA  
AROUND THE WORLD

RESEARCH REPORT  
MARCH 2021



# Understanding health-seeking behaviour of the Rohingya community

# Acknowledgement

This research has been carried out by Research and Learning Team, BBC Media Action, Bangladesh under the project 'Common Service for Community Engagement and Accountability' funded by EU humanitarian aid and the UK Foreign, Commonwealth and Development Office.

The authors would like to thank the people from the Rohingya community living in Cox's Bazar, Bangladesh. Thanks also go to Shorot Shadhin, Afroja Khanam, Anamika Dey, Imtiaz Bin Mostak and Arfat Habib for their immense support in data collection. The authors are grateful to Al Mamun and Kate Gunn for their valuable feedback and review.

BBC Media Action, the international development organisation of the BBC, uses the power of media and communication to support people to shape their own lives. Working with broadcasters, governments, other organisations and donors, we provide information and stimulate positive change in the areas of governance, health, resilience and humanitarian response. This broad reach helps us to inform, connect and empower people around the world. We are independent from the BBC but share the BBC's fundamental values and have partnerships with the BBC World Service and local and national broadcasters that reach millions of people.

The content of this report is the responsibility of BBC Media Action. Any views expressed should not be taken to represent those of the BBC itself or of any donors supporting the work of the charity.

Authors:	Nanjiba Zahin, Fuad Ur Rabbi
Editor:	Md. Arif Al Mamun
Graphic Design:	Hasan Altaf Mahmud
Copy editor:	Teresa Albor

# Contents

Introduction .....	1
Research objectives.....	2
Research methodology .....	3
Key Findings .....	4
Rohingya people’s knowledge about health services in the camp	4
Rohingya people’s practice of seeking health care	5
Formal health facilities and health-seeking practices.....	6
Challenges of seeking health care inside camp.....	11
Travelling to the facility	11
Inside the facility	11
Informal health services and health seeking behaviour .....	12
Community engagement and utilisation of feedback and response mechanisms at health facilities.....	15
Conclusion and recommendations.....	17
Annex 1:Detailed research questions.....	18
Annex 2:Health problems and cures suggested by faith healers.....	19

# Introduction

Cox's Bazar, in south-eastern Bangladesh, is home to the world's largest refugee camps. The Rohingya people living in these camps sought refuge having experienced physical and mental violence through atrocities carried out by the military in Myanmar. Currently, 866,457 Rohingya people are residing in in these camps, 52% are women and girls, 48% are men and boys<sup>1</sup>. The camps are congested and overcrowded which contributes to the health challenges Rohingya people of various ages and genders<sup>2</sup> face, including communicable and non-communicable diseases and other illnesses<sup>3</sup>. Conditions in the camps also form a public health challenge for the actors responding to the health care needs of Rohingya people<sup>4</sup>. Furthermore, the Covid-19 pandemic has affected the provision of essential services including health care.

To address these health challenges, health sector partners including the Government of Bangladesh (GoB), international non-government organisations (INGOs) and non-government organisations (NGOs) provide services to the Rohingya community. Currently 97 health posts, 38 primary health care centres, 23 specialized facilities and three field hospitals are operating in the camps<sup>5</sup>. Besides these in-camp facilities, patients can be referred to facilities outside the camps, when it is determined that availability of equipment, more skilled staff and other medical resources enhance the chance of patient survival.

Increasing Rohingya people's positive health-seeking behaviour and delivery of accountable health services have been highlighted as part of the key objectives of the health sector operating in the camps<sup>6</sup>. Health-seeking behaviour can be defined<sup>7</sup> as "any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy".

Existing literature indicates that Rohingya people have a negative perception of the health services available in the camps, and that there has been a decrease in health-seeking behaviour, especially during the Covid-19 pandemic<sup>8</sup>. The level of trust of health care services has gone down, raising concerns about

---

1 UNHCR Bangladesh (2021). Operational Update External #60 [online]. Available from: <https://data2.unhcr.org/en/documents/details/84980>

2 ISCG (2020). JRP 2020 Mid-term Review January-July 2020 - Rohingya Humanitarian Crisis [online]. Available from: [https://reliefweb.int/sites/reliefweb.int/files/resources/2020\\_jrp\\_mtr\\_final.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/2020_jrp_mtr_final.pdf)

3 World Health Organization. Bangladesh-Rohingya Crisis: Responding to health needs of vulnerable population (online). Available from: <https://www.who.int/bangladesh/emergencies/Rohingyacrisis>

4 Ibid

5 World Health Organization (2021). Rohingya Crisis Situation Report #2 [online]. Available from: <https://reliefweb.int/sites/reliefweb.int/files/resources/who-cxb-situation-report-2.pdf>

6 Inter Sector Coordination Group. (July-August 2020) Joint-Multi-Sector Needs Assessment, Bangladesh Rohingya Refugees [online]. Available from: [https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/msna\\_2020\\_factsheet\\_refugee.pdf](https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/msna_2020_factsheet_refugee.pdf)

7 Ward, H., Mertens, T. E., & Thomas, C. (1997). Health seeking behaviour and the control of sexually transmitted disease [online]. Health Policy and planning, 12(1), 19-28. Available from: <https://academic.oup.com/heapol/article/12/1/19/610545?login=true>

8 ACAPS (2020), Rohingya Response Health Behaviours & Covid-19 [online]. Available from: [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)

health-seeking behaviour<sup>1</sup>. It is important to note that in addition to the formal provision of health services Rohingya people use informal mechanisms to receive treatment<sup>2</sup>.

As such, to understand Rohingya people's current health-seeking behaviour, this qualitative, formative research study explores community engagement and accountability involving informal and formal entities including faith healers, formal health care providers and the Rohingya people themselves.

It covers factors which either enable or discourage Rohingya people to seek different kinds of health services and how they engage with these services. In particular, challenges during the Covid-19 pandemic are considered. And finally, this report addresses Rohingya people's utilisation of feedback and accountability mechanisms and their information needs.

These research findings will help BBC Media Action develop new or adapt current communication materials on health to increase Rohingya people's positive health-seeking behaviour. Furthermore, this research is intended to enable the health sector, including the Communication with Communities (CwC) sub-sector, create positive patient experiences at health facilities and strengthen existing accountability and community engagement mechanisms in the camps.

## Research objectives

This research aimed to understand Rohingya people's health-seeking behaviour, their barriers to accessing health services, their use of feedback and response mechanisms, and health providers community engagement and accountability approaches.

The objectives of the research are:

- to better understand Rohingya people's health-seeking behaviour;
- to identify Rohingya people's barriers to accessing health services;
- to document health providers community engagement and accountability approaches; and
- to investigate the degree to which Rohingya people use feedback and response mechanisms.

---

1 IOM and ACAPS (2020). The main health issue for all Rohingya men, women, boys and girls? COVID-19 Explained [online]. Available from: [https://www.humanitarianresponse.info/sites/www.humanitarian-response.info/files/documents/files/Covid-19\\_explained\\_-\\_why\\_trust\\_matters.pdf](https://www.humanitarianresponse.info/sites/www.humanitarian-response.info/files/documents/files/Covid-19_explained_-_why_trust_matters.pdf)

2 BBC Media Action (November 2020). Rohingya community concerns over health services in the camps [online]. *What Matters?* Humanitarian Feedback Bulletin. Issue 46. Available from: <https://app.box.com/s/aaypxzf8w9k5xq9b2fhmq115zsv6up4y>



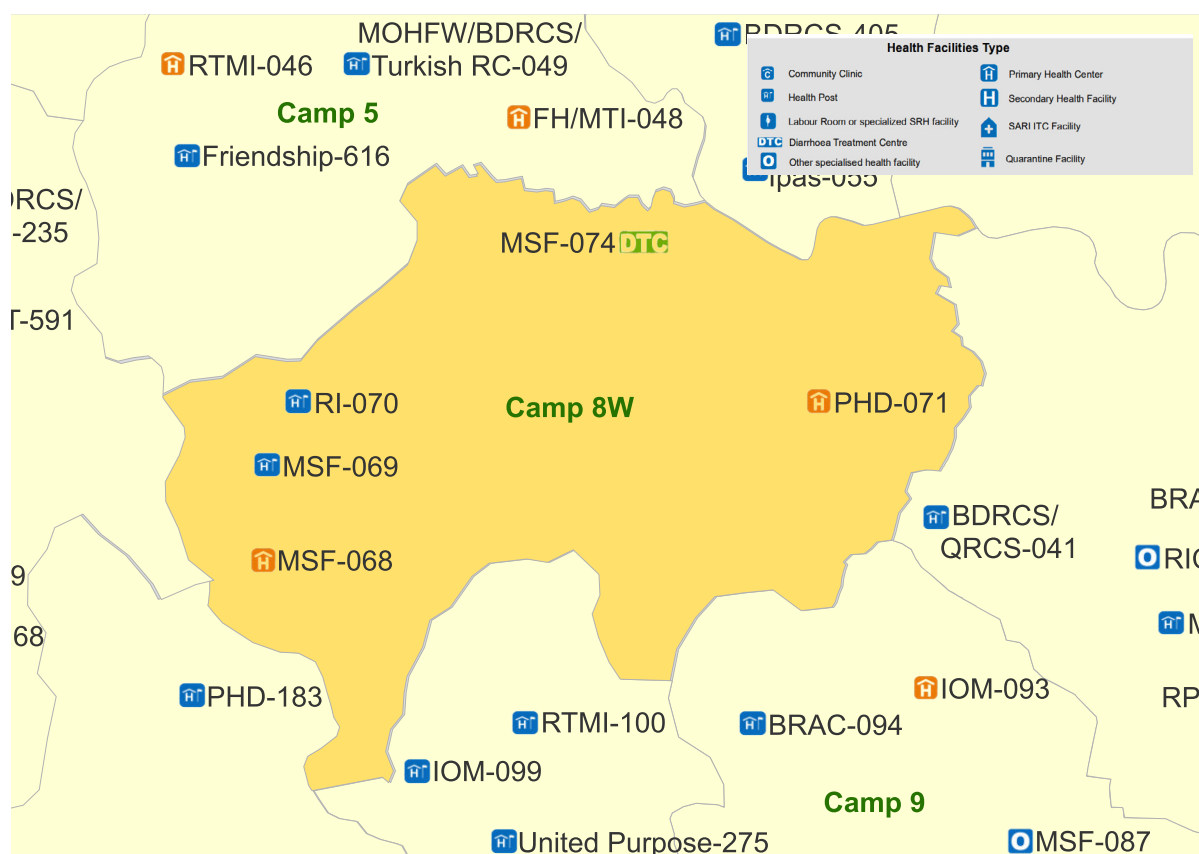
# Research methodology

For this study, qualitative research methodologies including paired-depth and in-depth interviews were used as data collection tools. 16 male and female Rohingya people, two formal health service providers (a practitioner and a volunteer) and four informal health service providers (faith healers) were interviewed. Guides were prepared for conducting pair-depth interviews with Rohingya people and for conducting in-depth interviews with formal and informal health care providers.

Rohingya Participants	Total	Health care service providers	Total
Male	8	Formal service providers	2
Female	8	Informal service providers	4
<b>Total</b>	<b>16</b>	<b>Total</b>	<b>6</b>

Camp 8W was selected because it has health posts, a primary health care centre and a secondary health care facility<sup>1</sup>.

As findings are based on one camp, this report should be seen as reflecting a general sense of Rohingya people's health-seeking behaviours and perceptions which might vary from camp to camp.



1 Health Sector Health Facility Maps: [https://drive.google.com/drive/folders/1s2PR4K8uA3cVhWk7\\_8wxOxn7DtxhQ-MP](https://drive.google.com/drive/folders/1s2PR4K8uA3cVhWk7_8wxOxn7DtxhQ-MP)

# Key Findings

## Rohingya people's knowledge about health services in the camp

### **Rohingya people develop their knowledge of formal health services and faith healers through their own experiences and information shared by their neighbours, relatives, and humanitarian agencies**

The common health problems which Rohingya people say they face include respiratory illnesses, different types of flu, broken and bruised limbs, aches, intestinal diseases, non-communicable diseases and issues related to sexual and reproductive health. Participants said they are aware of how to access in-camp treatment, facilities, and the referral system (to facilities outside the camps) because they have observed neighbours and through their own personal experiences taking care of themselves or an unwell family member. Neighbours and relatives discuss the treatment they receive and give each other advice. Volunteers and community health workers working with different humanitarian agencies also play a role in providing information about health services by going door to door.

Effectively, becoming unwell motivates them to become aware of the specific formal health services available, both inside the camp as well as private facilities outside the camp, and faith healers who offer cures for specific concerns. Since most have lived in the camps since 2017, they have had adequate time to become reasonably familiar with what is available.

All participants initially mentioned medical doctors as providers of health care. They said they go to '*daktar hana*' (doctor's place) and mentioned the hospitals or other health facilities by the name of the NGOs and INGOs who operate them, for example, International Organization for Migration (IOM), UNICEF, Partners in Health and Development (PHD), Turki/Turkish hospital, Relief International, Médecins Sans Frontières (MSF), or Food for the Hungry (FH). In addition, they said they go to faith healers for certain problems such as perceived possession by evil spirits, menstrual problems (which they say can be a result of possession), infertility, and so on (See Annex 2: Health problems and cures suggested by faith healers).

“Whenever we have any disease then we go for treatments and other people also go for treatments (at the health facilities), that is how we know (about health services).”

— Rohingya woman, 23

“When we went for treatments, we saw other people getting treatment. Besides, it's been many years that we are here in the camp. Slowly we got to learn (about the health services).”

— Rohingya woman, 23

Rohingya participants generally knew which services were available from the different formal health facilities inside the camp, which facilities were open 24/7 and on weekends, which were more likely to provide medicine, how to get to facilities (i.e., on foot or by transport), which were perceived to provide better treatment for certain health issues and had a sense of the size and capacity of the facilities.

Rohingya people also knew about health facilities outside the camp in Teknaf, Chattogram and Cox's Bazar. They mentioned Cox's Bazar Sadar Hospital, Al-Fuad Hospital, Ukhiya and the Teknaf Shyastho complex.

### Female participants want to know where to get information about health services

Despite having a general sense of what is available, female participants said they want to know more about which facilities/hospitals provided which services. They want to know where good treatments are available, the medicines available at facilities, and how to access services.



We want to know about medicines of which disease are available where, we want to know what will happen if we go somewhere. Now we don't know correctly."

— Rohingya woman, 33+

### Rohingya people's practice of seeking health care

Rohingya people's options include health facilities inside the camp, outside the camp or faith healers. Some said they go to more than one health facility in the camps until they find what they consider to be proper treatment (as evidenced by recovering from an illness). They said if they can't find treatment in the camps, they then seek health services outside the camps (especially for serious conditions) or go to faith healers. Some said that if they could afford it, they would go to private facilities outside the camp first.



If there is fever, headache then we can go to camp facilities. If it is a serious disease and there is no referral then we make our own arrangements. If doctors are unavailable in the camp in the evening, we wait and go in the morning. If facilities are closed, we go to the pharmacies and get medicines. In the morning, we go to Camp in Charge (CiC) for referral. If it becomes late, then we call a Rohingya doctor (faith healer) to the house."

— Rohingya man, 20+



# Formal health facilities and health-seeking practices

## Patient recovery is a factor which determines satisfaction with health facilities

If the treatment provided is helping the patient recover relatively quickly the health facility is perceived to be good; if not, the facilities and doctors are blamed. Patients are reluctant to make second visits if they do not recover or are not satisfied after their first visit.

Concerns were raised by some participants about their ability to identify the right facility for their needs, and the possibility that despite going to several facilities, they would not recover completely. For example, a female participant said she has been going from one health facility to another but cannot get the right treatment for her son who is not recovering (from an unidentified illness). She said she does not want to go outside the camp for fear of being trafficked or kidnapped. Another male participant said he took his son to facilities inside and outside the camp, and that his son was not given a proper referral. He says that although he was told it was not the hospital's responsibility to make referrals, he does not believe this. His understanding is that this is a matter of discretion i.e., that staff decide whether or not they will make referrals. His son died at a hospital in Chattogram.

Rohingya people perceive that while adequate treatment is available for '*gura*' or minor sickness in the camp, treatment for '*dor*', severe or chronic diseases is not available. Therefore, people consider going to facilities outside the camp if they can afford it, especially if they have heard that faster, better treatment is available.

“ If one hospital is not good, people go to another hospital, and if treatment is not good there also, they go to another hospital. [For example], having done this several times, they see people recover after going to the Turkey hospital.”

— Rohingya man, 20+

“ ...giving less medicine means the illness will not be cured.”

— Rohingya woman, 30+

“ Treatments outside the camp are done nicely. The cause of the illness is found, for example, for BDT 10,000 (about Euro 100) an X-Ray is done, and the disease is found.”

— Rohingya man, 20+

“ If people go outside (the camp), they spend money, get treated and are satisfied. Treatment outside is good. If people go outside, they recover after spending their own money.”

— Rohingya man, 20+

Participants said they appreciate having Rohingya translators or volunteers at the facilities who help them understand doctors. They also appreciate the door to door visits of volunteers from different agencies who facilitate/indicate who needs to go to the hospital. These volunteers, available in each block, also provide health information such as tips about keeping children healthy.

Furthermore, they appreciate the fact that facilities inside the camp provide treatment free of cost for everyone and that referrals given by hospitals are managed by hospitals, i.e., transport is arranged free of cost.

However, participants complain about waiting a long time in lines for services, sometimes becoming so frustrated they give up.

### **Quantity of medicine plays an important role in people's decision making about where they seek treatment**

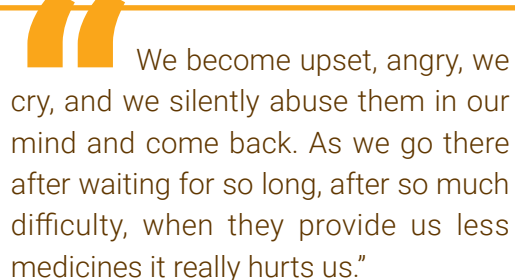
Rohingya people perceive that health facilities which provide more medicine are better than those which provide less. They are not satisfied if they don't think they've received a sufficient quantity of medicine, especially if they've had to travel a long way over hilly terrain. They don't complain because they think they will be scolded by doctors or service providers.

Rohingya people go to more than one facility if they think the second facility will provide more medicine. For example, one female participant said she went to two facilities, one provided more medicine, so she credits that facility with the patient's recovery.

If Rohingya people think they need additional medicine they go to pharmacies outside the camps to purchase it. Depending on their symptoms, they may purchase medicine without going to a health facility first for advice. (Examples given included feeling weak or gastrointestinal problems.)

Rohingya people believe that more expensive medicines help one to recover faster from diseases. They also want doctors in health facilities to provide energy boosters/ vitamins so they don't have to purchase them, since they believe these are essential.

Health service providers said medicine stock insufficiency is an issue. Medicine is not always available even if it is prescribed. It is reported that doctors/people at health facilities have told patients that they are providing what is available vs. a more appropriate medicine which is not available.



“ We become upset, angry, we cry, and we silently abuse them in our mind and come back. As we go there after waiting for so long, after so much difficulty, when they provide us less medicines it really hurts us.”

— Rohingya woman, 22+

This can lead to mistrust of the doctor's diagnosis especially since Rohingya people believe that the quantity of medicine is related to the speed of recovery. For example, if the first facility provides one type of syrup, and the second provides five types of syrup, Rohingya people are more likely to believe the diagnosis of the second facility.

Some Rohingya people said foreign doctors are better as they are better educated, have more expertise, and provide more medicines.

Despite these frustrations, they said they understand and acknowledge that doctors deal with lots of patients and thus may have to ration medicine and have less time to spend with patients.

Practitioners said some Rohingya people overestimate the value of medicine and underestimate the importance of having a healthy lifestyle. Another said patients present with vague symptoms. Finally, a practitioner said that sometimes a smaller quantity of medicine is provided because of concerns Rohingya people may sell medicine if given in large enough quantities.

## Fears of Covid-19 reduced visits to health facilities

When coronavirus pandemic containment measures were introduced in camps, Rohingya people feared visiting health facilities. They said they thought that if they went to facilities for treatment, they would have to stay for 10-12 days, be taken away or even killed. Some said they thought doctors were not attending facilities due to the pandemic.

Health professionals confirm that there were rumours and misinformation about isolation and quarantine. However, over time, public health information helped dispel these rumours and misunderstandings. Although Rohingya people are no longer as fearful of Covid-19, they are still concerned since they are aware that there are

“ Even if I go with two or three illnesses, they will give less medicines. I told them I had gastric problems, fever, and body ache. But they only gave paracetamol. But then only my fever would recover, other illnesses will not get solved. I don't feel like going when they don't have medicines.”

— Rohingya woman, 30+

“ They (one particular facility) provide less medicine. They always give paracetamol. They do not give us the quantity of medicines which are allocated for us.”

— Rohingya woman, 30

“ It is going to be one year that we are not receiving good treatment because of Corona virus. Before they used to check children with instruments but now due to coronavirus, they're not doing any examination using instruments. At all hospitals medicines are being provided at a distance.”

— Rohingya woman, 22+

serious or even fatal cases. And despite public health communication efforts, some persist in believing rumours about isolation and quarantine. Health professionals said that it is a reality that patients with fever, a symptom of Covid-19, must be tested and isolate. This keeps people from seeking health care at facilities and makes managing the pandemic and providing health services difficult for professionals. Furthermore, once at the facility, due to the pandemic, doctors and health professionals have taken infection prevention measures, i.e., they do not use instruments like stethoscopes and maintain a safe distance from patients. This, in addition to mandatory mask wearing and hand washing at facilities, has caused further misunderstandings about the standard of care.

To counter negative perceptions and rumours, community and religious leaders (mahjis and imams) were invited by the practitioners to facilities where procedures and treatments were demonstrated and explained to them. Since these community leaders were all men, female Rohingya volunteers were recruited to be a part of health facility teams. This was well received, and community leaders did, indeed, reassure people about the importance of going to health facilities. One practitioner said this approach was effective and increased the number of people coming to facilities.

“ If I talk about the situation before and now, there is a sky-high difference. Earlier (just after Covid-19 arrived) they did not want to come to the facility, they used to hide their symptoms. But now they themselves come forward with their symptoms.”

— Practitioner, health facility

## Rohingya people have an incomplete understanding of referral mechanisms

Through word of mouth, Rohingya people have developed an understanding of the concept of ‘referrals’<sup>1</sup>. They understand that when health facility staff determine that a patient needs treatment which is unavailable at that facility, transport will be arranged and costs will be covered for a patient to be sent to another facility inside or outside the camp. For example, some pregnancies result in more complex deliveries best done at hospitals outside the camp.

1 “Besides the three core components of emergency medical care – care in the community, during transportation and on arrival at health facility— for emergency cases, patients need to be referred to facilities where availability of equipment, more skilled staff and other medical resources enhance the chance of survival. This whole process is called the ‘referral system’.” (WHO)

“ If treatment cannot be done at one hospital, then the patient is sent to another hospital, for example, if not at MSF then patient is sent to Kutupalong MSF or Cox’s Bazar Medical.”

— Rohingya man, age 20+

“ They refer us to good places. My son got better. This thought makes me feel good.”

— Rohingya woman, age 23

However, there are limitations to the process that cause misunderstandings :

Sometimes, two or three people want to go with the patient to the referred hospital, which is not possible.

In some facilities services such as food are not always provided for the patients.

A hospital in Cox's Bazar, to which many patients are referred, has a limited capacity which means there can be long waits for transfer/admission.

Not all medical diagnostics are free at referral facilities and NGOs must make decisions about how to use their limited resources; this is understandably, especially difficult to explain to patients and their families.

Ambulances cannot reach certain houses in the camps due to narrow roads or other environmental conditions.

“ Now they are much more well-oriented than before (about referrals). They understand that if treatment cannot be done at one place [an in-camp facility], they will be sent somewhere else [possibly an outside facility]. It was difficult to make them understand this before, but now they do.”

— Practitioner, health facility

“ It is very difficult to get a referral, sometimes we have to pay BDT 500 (Euro 5) to arrange one. Otherwise, we need to wait till evening and come back empty handed. I also heard that we need to give money for tea to get a referral.”

— Rohingya man, 20+

Since Rohingya people perceive facilities outside the camp to provide better treatment, and because it is mandatory for Rohingya people to show their referral slips at checkpoints, it is alleged families pay bribes for referrals.

# Challenges of seeking health care inside camp

## Travelling to the facility

**Difficulty reaching facilities far from home:** The camps are located in hilly terrain and health facilities can be far from some parts of the camp. For example, in camp 8W, people living in block D have to walk some distance including a steep ascent to the top of a hill to reach some facilities. This is difficult for children, elderly and unwell people.

People prefer to go to facilities close to their home, however they are prepared to go to a hospital or facility which is further away if it is thought to provide the best treatment.

**Poor conditions of the roads:** During monsoon season bridges get washed away, pot holes emerge, road surfaces deteriorate and mud is a problem, making it difficult for people to go to facilities and practitioners to provide services.

To reach facilities, patients often walk or are carried (sometimes by paid 'bearers') on makeshift stretchers made of bamboo, chairs, and blankets.

**Problems faced at night:** There are places in the camp without public/outdoor lighting. Furthermore, arranging to carry patients at night is more difficult and female volunteers are less likely to leave their homes to support patients.

## Inside the facility

**Waiting in queues is difficult:** After hospitals close for admissions, those in line must leave and come again the next day. It is possible for patients to wait for hours without being able to see a doctor. Some give up and don't return.

Health professionals find maintaining the flow of patients challenging. Generally, there are more patients in the morning. Facilities use the triage method which means priority



As the hospitals are very far, people do not want to go there. They sit at home without going for any treatment. Those who are elderly and have no one to take them to the hospitals – they don't want to go."

— Rohingya woman, 52



Ambulances cannot reach all sites inside the camp because of being cramped and hilly. This is a very time-consuming issue and causes delays in providing emergency services."

— Practitioner, health facility



is given to those who are seriously ill. Patients are assessed and given a status of 'red', 'yellow', or 'green'. This can be confusing and frustrating for patients, but it is generally accepted once understood.

**Women may feel shy/reluctant to discuss health problems:** Culturally and religiously inhibited, Rohingya women can be reluctant to discuss their health with male doctors. Although female volunteers are there to assist, sometimes symptoms are not clearly described making it more difficult at times to diagnose and treat women.

Rohingya people appreciate the health services provided, despite these complaints.

“ Grateful. Without the health services, we would have no other place to go to.”

— Rohingya man, 50+

“ It is good to receive health services inside the camp as it is easy to go there, family members can visit the sick people. If patients are taken outside, no one can see him/her if s/he dies.”

— Rohingya man, 20+

## Informal health services and health seeking behaviour

### As they did in Myanmar, Rohingya people distinguish between illnesses to be cured by doctors and illnesses to be cured by faith healers

Besides formal health care services, Rohingya people also seek treatment from informal health service providers such as faith healers or those they call 'Rohingya doctors' (who do not have formal qualifications), thereby continuing a practice which was prevalent in Myanmar. Faith healers are also known as *moulana*, *fokir*, *imam* and *hujur*. Informal health service providers interviewed for this study were all Muslim men. They said they use Quranic verses and different books as sources of treating people's health issues. Besides the Qur'an, one book, '*Hekme Tofelaton*' written in Urdu, can be purchased from the camp market. Most were practicing in Myanmar before coming to Bangladesh, having learned from religious leaders.

“ We found out that it is possible for sick people to recover after going to doctors only after coming to Bangladesh. We didn't know this back in Myanmar. We used to go to *boiddos* (informal doctors) back in our country, the Myanmar hospitals are really far.”

— Rohingya man, 50+

Faith healers provide treatment for problems such as stomach-ache (including lower abdomen), headaches, dizziness, body aches, problems with nerves (hands and feet), swollen wrists ophthalmological problems, infertility issues, children getting scared at night and trembling, men having hernias, loss of appetite, etc.

Rohingya people believe some specific conditions can only be cured by faith healers: those caused by evil spirits, such as acting 'mad', and menstrual problems seen as resulting from possession.

Participants made a distinction between when it is appropriate to go to a faith healers vs a doctor. For example, they said faith healers cannot treat diarrhoea or colds. Similarly, if it involves an evil curse they said doctors would be of no help. Therefore, they categorise conditions as 'doctor's diseases' or 'faith healers diseases'.

Rohingya people identify the signs of evil spirit possession as chattering teeth, being scared at night, not being able to walk properly, eyes rolling back, or behaviour that could be perceived as being 'mad'. They said that if children's play patterns change and they are scared at night, they may be possessed by evil spirits and as a result, might also become weak. (See Annex 2: Health problems and cures suggested by faith healers.)

### Several factors play a role in people's decision to go to faith healers

Rohingya people said that if they don't recover after visiting doctors several times, they go to faith healers. They say the amulets, the practice of 'blowing' after reciting verses from the Qur'an and so on are comforting. And if people fall ill at night or when doctors are unavailable faith healers are usually accessible.

### Rohingya people believe menstrual problems are a sign of possession and require treatment from faith healers

Rohingya women go to faith healers when menstrual bleeding doesn't stop after a week or if their periods are irregular since these can be a sign of evil spirits. They also go to faith healers for infertility and pregnancy issues.



If there is dizziness, if someone has a bad dream, or always feels bad, these are not diseases for doctors. If faith healers blow air after reciting chants/prayers, they can cure these conditions."

— Rohingya woman, 43



... I don't go to them (*boiddos*) but people from this area go. When children are sick or have fever, if the doctor is unavailable – then they go to them."

— Rohingya man, 22+



Women having menstrual pain, not having children – these are diseases for the faith healers. If faith healers give amulets, they can recover."

— Rohingya woman, 32+



Women say that because of evil spirits, their menstruation stopped, or their bleeding was not stopping."

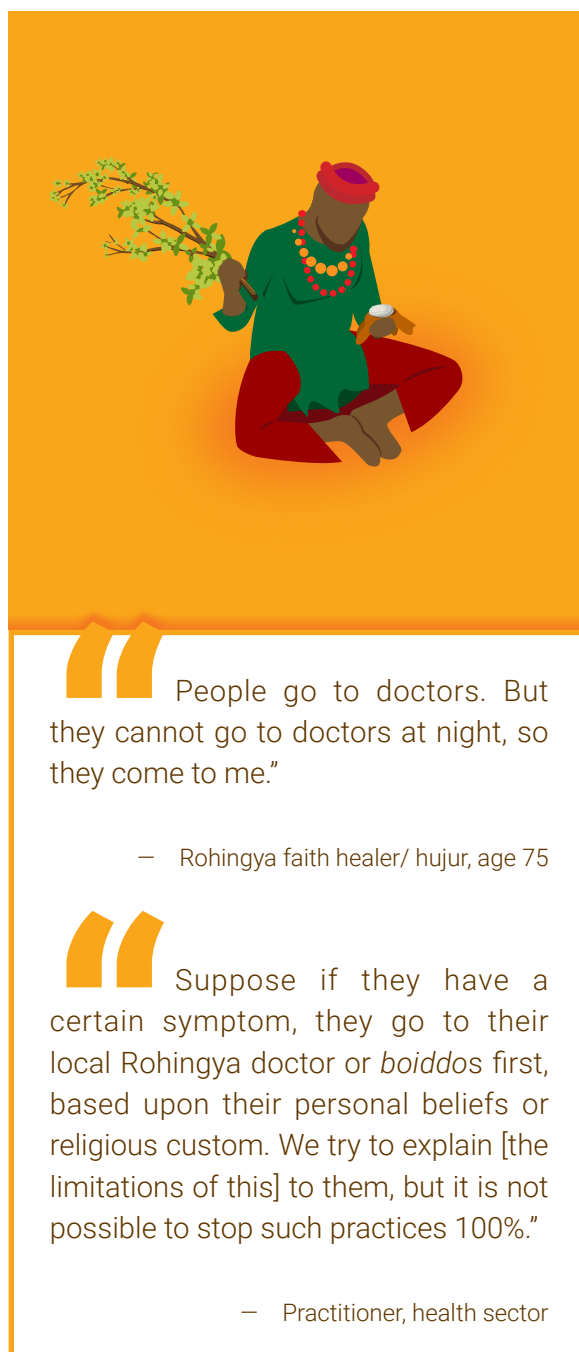
— Rohingya faith healer/hujur, 70+

## Faith healers know they cannot cure all health problems

Rohingya people choose when to go to faith healers who are often willing to attempt to help. However, faith healers said that if they cannot help, they do not hesitate to recommend doctors and hospitals. They themselves go to doctors, as do their family members. One informal practitioner said people come to him simply because he can provide treatment quickly vs. the prospect of going to a distant hospital and waiting in line for a doctor, especially if one is in pain.

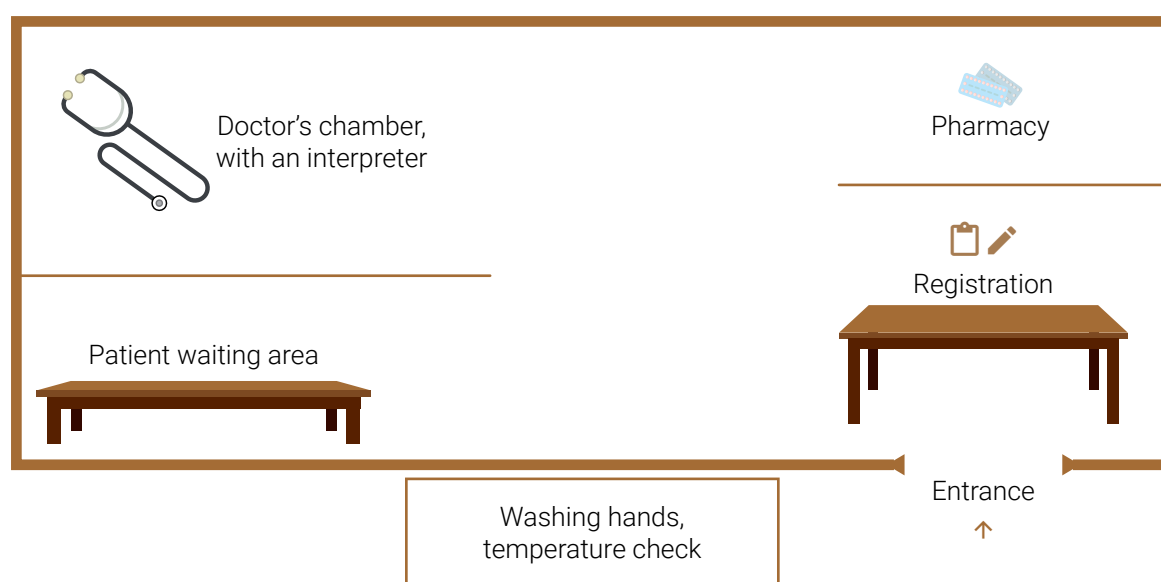
In the camps, all the faith healers provide and use similar materials and methods of treatment, which is to recite verses from the Qur'an, read certain religious books written in Urdu, and 'blow' on the ill-person's forehead (ঝাড়ফুক), give holy water (পানি পড়া) (water 'blown' after reciting Quranic verses), amulets (তাবিজ), holy oil (তেল পড়া), or other materials.

Practitioners acknowledge that Rohingya people visit faith healers based on deep rooted beliefs and superstitions. They say they discuss this with people but acknowledge that shifting attitudes will take time.



# Community engagement and utilisation of feedback and response mechanisms at health facilities

## Journey inside health facilities



In general, to receive treatment at a health facility, people need to interact with a range of staff: the security guard at the entrance, volunteers, registrars, medical interpreters/translators, doctors, and pharmacists.

Normally, people are happy with the services provided at health facilities. However, some say that due to communication barriers, doctors or volunteers scold them if ask 'too many' questions.

### **Rohingya people are not clear about complaint and feedback mechanisms**

This research found that in general Rohingya people do not know how to provide feedback or lodge complaints about health services. Those

“ The doctor who gives medicines explains to us how to take which medicine. If we don't understand, then the volunteer explains this to us.”

— Rohingya woman, 30

“ There are many doctors who are hot-headed. If patients don't understand something about the medicine and ask repeatedly about it, doctors scold patients. I've seen this happen with people.”

— Rohingya woman, 52

who do know, hesitate to provide feedback or make complaints as they fear it will affect their treatment.

In health facilities, the following are available, according to health professionals:

- Outpatients can use complaint boxes. There is signage and forms with facial expressions (happy, sad and angry faces) and questionnaires which ask for feedback.
- Some facilities collect random feedback from outpatients.
- Patients are asked for feedback, once admitted to facilities.
- Supervisors and doctors on rounds ask for feedback.
- Mental health counsellors are available.
- Volunteers and community health workers (CHW), as well as their supervisors, visit people's houses which is an opportunity for people to provide feedback or make complaints.
- Mahjis and imams can pass on observations, suggestions, and complaints at camp coordination meetings with Camp in Charge (CiC).

“ It is scary, they are big, and we are small, we took shelter here in Bangladesh after coming from another country. If after making complaints they behave badly with us, we will feel embarrassed and insulted. That is why we don't complain.”

— Rohingya woman, 30

“ I do not know how complaints can be made regarding health services. No one told us. It would be good if you can tell us.”

— Rohingya woman, 22+

“ People can complain to us (health professionals) directly, they can inform CiC, or CHWs when they visit their homes, when they visit the facilities. Places to complain are different from one place to another.”

— Practitioner, health sector

There is a communication gap since Rohingya people seem unaware of how to provide feedback whilst formal health care service providers seem to indicate there are multiple, obvious mechanisms.

# Conclusion and recommendations

Rohingya people's choice of health services depends on their experiences, types of illnesses, and time when the service is required. They, over time, have come to have some understanding of where and what services are available at facilities, and get information from volunteers. Therefore, they go to different formal health facilities – health posts, primary health care centres and hospitals, as well as to informal service providers – faith healers, to avail of different health services. Going to faith healers for treatment is a deep-rooted practice in the Rohingya community, as it was in Myanmar. There are some specific health concerns people perceive as best taken to faith healers (possession by evil spirits, speeding up childbirth and infertility).

The quantity and variety of medicines prescribed by health professionals plays a crucial role in Rohingya people's decision of which health services to use. There is a wide-spread perception that consumption of more medicine will make recovery faster, despite the type and nature of the disease. Some judge the quality of the service and diagnosis by the quantity of medicine provided. They perceive that health facilities situated outside the camps provide better treatment. They do not have a clear understanding of the referral system (necessary to travel outside the camps for treatment).

Although there are provisions and initiatives have been taken by health professionals to provide clear information about outreach services, services available at facilities and complaint and feedback mechanisms, there is still work to be done.

This study recommends the following:

**Continue health education efforts** at the community level emphasising preventative practices and that it is not necessary to take medicine for all diseases. These efforts could take the form of training activities or other community information products.

**Enhance community engagement** initiatives regarding health services encouraging positive health-seeking behaviour through formal provision.

**Improve awareness of complaint feedback mechanisms** which exist but are not extensively used. Since feedback and complaint collection varies from agency to agency, a standard mechanism to be used across all health facilities could be developed.

**Develop behaviour change communication** to debunk beliefs around the need to take a lot of medicine to recover from an illness, and about healthy lifestyle choices such as diet, exercise and preventative measures, referral systems (how it works) and complaint and feedback mechanism. In addition, thematic issues could be covered such as menstrual problems and infertility. Communication products such as posters and audio-visuals for Rohingya people and flipcharts for practitioners about best practice in providing health education are recommended.



# Annex 1:

## Detailed research questions

Research objective	Research questions
Research into people's health-seeking behaviour	What do people do when they wish to seek health services? Where do they go?
	What do they know about available health services in the camps? How did they learn about these?
	Which factors motivate them to receive health care services in the camps?
Research to understand people's barriers to accessing health services	What kind of problems do people face while going to the health facilities?
	What kind of challenges do they face once inside health facilities?
Research to understand people's use of feedback and response mechanisms	How do they interact with the service providers at the health facilities? How was their experience?
	How does community engagement take place to share available/ updated information regarding health services?
	How do they raise their concerns or provide feedback about the health care service they received/were seeking to receive?
	What challenges do they face providing feedback or placing complaints about health facilities?
Research into the health providers community engagement and accountability approaches	What mechanisms are in place to collect people's feedback and complaints about the health care services they received?
	What kind of challenges do the practitioners/health care service providers face while engaging with Rohingya people?
	What do they think motivates and discourages people when seeking formal health care services?

## Annex 2:

# Health problems and cures suggested by faith healers

Health problem

Cure suggested by faith healers

---

**Body ache and headache**

When someone has a headache, their eyes may turn red, and their nerves get a bit swollen; this happens when the person is possessed by evil spirits. When people don't pray properly, God punishes them with headaches/possession. The cure involves reciting verses from the Qur'an and 'blowing' on the sick person, and/or giving the person an amulet. The person will recover in two hours.

*"Those with general headaches will go to doctors and recover after having medicines. And those whose headaches because they are possessed by jinn or evil spirits come to me." – Rohingya faith healer/fokir, 44*

---

**Leg fracture and dislocated joint**

Massaging the location with mustard oil.

---

**Swollen nerves**

Massaging the location with mustard oil. If the pain is extreme, one faith healer said he recommends people go to doctors.

---

**Hernia**

Men fear that doctors might recommend operations while a faith healer will recommend something less invasive. Cure suggested by a faith healer is to hang an unripe brinjal at home for 41 days, 'blowing verses' on it three times a week ('এক শিরা').

*"Patients with hernia fear operations, they think they will die. They are not educated, and they have no knowledge about this. So they come to me." – Rohingya faith healer/fokir, 44*

---

**Stomachache**

This can be caused by someone casting an evil eye on the person or after eating certain foods. The cure is holy water 'blown with verses' from the Qur'an, and/or eating onions (পেঁয়াজ পড়া)

---

---

### Acting 'mad'

If someone behaves abnormally and acts in a crazy manner a faith healer might recite a chapter from the Qur'an (Surah Jinn) and then 'blow verses' on water and give the water to the patient to drink. People are also given oil 'blown with verses'.

---

### Eye pain

When eyes turn red, or are swollen, itchy and teary, people go to the imam to seek relief. The cure is water 'blown with verses' with which to wash their eyes.

---

### Speeding up labour

Imams provide holy water 'blown with verses' from the Qur'an for pregnant women to speed up labour. If women are unable to give birth to the baby at home ('বাচ্চা খালাস না হইলে') they are taken to the hospital.

*"During delivery if the baby does not come out, then the holy water can help deliver the baby. The water needs to be rubbed on the stomach of the pregnant mother."* – Rohingya faith healer, 63

*"There are women who want to deliver babies at home as they are shy and don't want to go to the hospital. They do not wish to discuss 'private issues' with doctors. Back in Myanmar, babies were delivered at home. Now they do it in hospitals. However, they prefer to deliver at home."* – Volunteer, health facility

---

### Children getting scared at night

When children (age 2-3) cry, tremble and cannot sleep at night, they are said to be possessed. Faith healers give them holy water 'blown with verses' and amulets. Amulets contain verses from a book written in Urdu. Children wear the amulet for one and a half months.

---

### Infertility

People are asked to bring honey. The faith healer 'blows verses' on the honey and asks the woman to consume it. Another faith healer, a moulobi, would 'blow verses' on 41 cloves and give an amulet to the woman, who would then be expected conceive children within 2-3 months.

---

### Menstruation

Holy water 'blown with verses' is given to women. If a woman doesn't have menstrual pain but has pain in her lower abdomen, one faith healer said he would give the woman an amulet.

*"Women say that because of evil spirits, their menstruation stopped, or their bleeding was not stopping."* – Rohingya faith healer/hujur, 75

---



**BBC**

**MEDIA ACTION**

TRANSFORMING LIVES THROUGH MEDIA  
AROUND THE WORLD

Registered office: Broadcasting House, Portland Place,  
London W1 1AA, United Kingdom

Registered charity number  
(England & Wales): 1076235

Company number: 3521587

Tel: +44 (0)207 481 9797

Email: [media.action@bbc.co.uk](mailto:media.action@bbc.co.uk)

Web: [bbcmediaaction.org](http://bbcmediaaction.org) and  
[dataportal.bbcmediaaction.org](http://dataportal.bbcmediaaction.org).