

‘Medicine In Name Only’

Mistrust and COVID-19 Among the Crowded Rohingya Refugee Camps in Bangladesh

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Abstract

This article is an anthropological examination of the health-seeking behaviours of Rohingya refugees living in crowded camps in Bangladesh, in the context of the COVID-19 pandemic. One international organisation providing medical care in the Kutupalong camp has found non-cooperation among the residents regarding the health facilities on offer to them. This ethnography highlights the Rohingya refugees’ active ‘mistrust’ (Carey 2017) of these medical services. We argue that these prevalent forms of mistrust provide a lens through which their individual life trajectories and politics can be understood in the context of the history of their systemic oppression by the Myanmar government. We reflect on the precarity and vulnerability of the Rohingya refugees, within which they identify mistrust as a source of resistance and protection. The mistrust of the Rohingya communities also highlights their attempts to communicate with a global public (Canetti 1960) and exhibits the ‘crowd politics’ (Chowdhury 2019) within a continued statelessness which is engendered by the Bangladeshi and Myanmar governments. This article makes an original contribution to the discussion of trust, mistrust, and rumour in society, identifying ‘the crowd’ as a site of resistance, and providing an account of the distinctive experience of the Rohingyas as refugees, and their health-seeking behaviour in the camp.

Keywords

Mistrust, COVID-19, Rohingya refugees, Displacement, Statelessness.

Introduction

There is no treatment of chronic disease for us. Whatever health problem we have, they give us only paracetamol. They give us medicine in name only.

In an interview held over WhatsApp, Lwing Naing,¹ a young Rohingya activist and NGO volunteer in Kutupalong,² a government-run Rohingya refugee camp in Ukhiya, Cox's Bazar (south-eastern Bangladesh), repeatedly expressed immense dissatisfaction about the healthcare services offered to the Rohingya people in this camp and others. We had interviewed him in the course of our COVID-19 related project,³ which aimed to understand household decision making in the context of the pandemic. Hearing similar stories from many other Rohingya informants in our ongoing research among the Rohingya refugee communities made it evident to us that they were dissatisfied with the healthcare facilities in these camps—and were refusing to avail themselves of these facilities even when they had symptoms of COVID-19. Lwing Naing's statement about insufficient health services first highlighted to us the need to understand this conundrum through the lens of mistrust. His comment and the title of this article capture an active mistrust towards medical authorities, rather than a resentment or dissatisfaction caused by an indifference on the part of camp authorities. An observational report from international non-governmental organisation (NGO) Médecins Sans Frontières (MSF), whose staff are working in these camps, also confirmed this conundrum. The MSF report noted that the numbers of Rohingya patients attending camp hospitals, either for chronic disease or with COVID-19 symptoms, had decreased during this period (Médecins Sans Frontières 2020). The report notes: 'Over the last few weeks, we have seen a stark decline in patient numbers. Our facilities have emptied; we are seeing half the number of patients we would normally' (ibid.).

Given the crowding and shared toilet facilities in the camps that create suitable conditions for the spread of the SARS-CoV-2 virus, Rohingya refugees are meant to report their COVID-19 symptoms and will then be placed in isolation units.⁴

- 1 All names of research participants are pseudonyms.
- 2 There are in total 33 registered camps in Kutupalong (Ukhiya) and Noyapara (Teknaf), in the Cox's Bazar district. Our respondents are from Kutupalong camp. Camp 23 in Shamalpur was officially declared closed in December 2021 by the Bangladeshi government in order to make way for tourism activity.
- 3 This article is based on ongoing research as part of the project 'Household Dynamics and Decision Making Under COVID-19' (IRB reference number: HIRB00011203). In this project, we investigate decision making challenges among Rohingya refugee households in Teknaf, Bangladesh, alongside those of other vulnerable groups in Bangladesh.
- 4 Social distancing or isolation is impossible in the Rohingya refugee camps, where up to ten family members can live in a single room measuring 10 x 16 ft²; up to 20 people share one outside toilet; and there are 40,000 people living in each square kilometre (World Vision n.d.; Ratcliffe et al. 2020). Organisations working in the camps, such as MSF, Care, ICDDR, B, and UNICEF, have therefore set up COVID-19 isolation and treatment centres to provide treatment as well as to prevent the spread of infection.

However, during the period of our fieldwork in 2020–2021, enquiries by health workers about COVID-19 symptoms among refugees received only negative responses, and nor have the health workers received any notifications of symptoms from the refugees themselves. While it was apparent that there was mistrust on the part of the Rohingya communities towards the existing medical services in the camps, we wanted to further understand and contextualise this mistrust. Why was a young Rohingya man like Lwing Naing not willing to avail himself of the health services and COVID-19 isolation units (provided by MSF) in the context of the pandemic? This decision not to do so is particularly significant in light of the availability of food and comfortable space in these isolation units, when compared with the crowded and shared spaces in the camp. Health service dissatisfaction and mistrust among people are evident across society and culture, yet the root causes are different and contextual. As anthropologists, we are keen to understand the specificity of the dissatisfaction with and mistrust towards these healthcare facilities in the Rohingya camps so as to inform healthcare providers, policymakers, researchers, and academics working in the field of refugees and with others who have experienced trauma.

Since 2017, over 800,000 Rohingyas have fled persecution based on contestations related to their ethnic identities and claims within Myanmar. Fleeing over the country's border with Bangladesh, they have been housed in crowded camps in the south-eastern part of Bangladesh, which has led to local tensions. In the context of COVID-19, governmental organisations and local and international NGOs who are providing medical and healthcare services have found resistance among the Rohingyas living in the camps to seeking healthcare, as captured by Lwing Naing's phrase 'medicine in name only'. Following Nusrat Chowdhury's (2019) work on crowds as a site of resistance, we extend this argument to observe that the crowds in the camp offer a source of protection for the Rohingya refugees, who mistrust the facilities within the camp. Unlike Chowdhury's formulation, however, the Rohingya communities living in the overcrowded camp are not a mob nor a political mass with direct democratic potential; rather, in their capacious configurations, they are different entities that are different to Chowdhury's original 'crowd'. The Rohingya crowds show how protection and resistance are closely intertwined in the proximate inhabitation of camp life. Recent anthropological literature has highlighted the role of mistrust as a social phenomenon (Carey 2017; Mühlfried 2019; Brown and Marí Sáez 2020; Yarrow 2019) and has also called attention to the relationship between dangerous intimacies and mistrust (Broch-Due and Ystanes 2016). This article examines the health-seeking behaviour in the refugee camps through the lenses of trust and mistrust that prevail among the Rohingya crowds. Through these lenses we also seek to stress the need to

historicise Rohingya health-seeking behaviour in the context of their flight from Myanmar. This perspective is often absent from NGO literature (e.g., MSF 2020). We argue that the elaboration of trust and mistrust is particularly important; they need to be conceptualised not as oppositional but as intertwined and relational to the context. Our ethnographic exploration attributes the Rohingyas' resistance to the circulation of misinformation and to mistrust in the health services on offer to them. This resistance differs from the response of the Bangladeshi population to COVID-19 given the state of immobility, incarceration, and surveillance in and under which the Rohingya refugees are kept, and within which they have to negotiate their health.

In this article, we will explore the form⁵ of rumour and misinformation circulating among the crowds of Rohingya refugees and follow recent anthropological literature on mistrust as a positive social phenomenon (Carey 2017). We also show the different kinds of trust that cohere through non-intimate forms of sociality (Broch-Due et al. 2016), such as that of online access. We argue that the forms of mistrust which are prevalent among the Rohingyas constitutes a lens through which their individuated life trajectories and politics can be understood in the context of their history of systemic oppression by the Myanmar government. Finally, we examine the occasion of Rohingya expression of mistrust towards health services, with the aim of better understanding how Rohingyas understand and relate to the larger humanitarian and governmental infrastructure that scaffolds life in the refugee camps.

The mistrust shown by the Rohingyas towards healthcare provision in the camps is a manifestation of a wider suspicion that such infrastructures intend harm rather than assistance. The very pathologised situation of the camp (its density and crowdedness) is instead made to work in the Rohingyas' favour as a means of supporting one another—as well as a way of withdrawing from the infrastructure that is provided by others. This physical withdrawal from existing health facilities is almost like a withdrawal of consent to the authorities, and represents a deep threat to the legitimacies of national and international organisations who are at work there, calling for a rethink of their position and activities. Overall, this article makes original contributions to the discussion of trust, mistrust, and rumour in society; identifies the crowd as a site of resistance; and provides an account of the distinctive experience of the Rohingyas as refugees, and their health-seeking behaviour in the Kutupalong refugee camps.

5 We use the term 'form' to indicate the process and historicity through which rumour, trust, mistrust, and kinship achieve specific meanings when considered contextually.

Remote ethnography

The article is an ethnographic exploration engendered through WhatsApp audio and video calls with Rohingya refugees living in various camps in Kutupalong, Ukhiya. It is an attempt to provide a nuanced account of the health-seeking behaviour of Rohingya refugees beyond the negative stereotypes of these people generated by the host community and media as illicit drug or arms dealers. The airborne virus SARS-CoV-2, which causes COVID-19, has limited the scope of the planned empirical study, which is 'essentialised' by the researchers' physical presence—in other words, 'being there' in the same location as one's interlocutors. As a result, we made contact with our respondents through a key informant and undertook discussions remotely. Our analysis draws upon remote interviews with health service providers and members of Rohingya communities from various camps in the Cox's Bazar district. Although the form it has taken is not ideal for anthropological research (that is, without physical presence), empirical research carried out remotely has, nonetheless, still allowed us to communicate with informants on an intimate basis. Informants contacted us at their own convenience, which made the interactions spontaneous. We tried to overcome the gap of physical absence from the camps in Kutupalong, Ukhiya, by watching documentaries, video clips available on the internet, and also through considering the pictures spontaneously and voluntarily sent by our respondents. Furthermore, despite the physical absence of an ethnographer, these remote interviews allowed us to connect with various people within a relatively short time.

We carried out an in-depth online ethnography based on pre-existing field contacts among Rohingya communities in Bangladesh⁶ between July and September 2020.⁷ Using a combined theoretical approach informed by medical anthropology, the anthropology of mistrust, the anthropology of violence and memory, and the anthropology of refugee and displacement, the project undertook an online ethnographic study of the narratives of the Rohingya community in order to generate fine-grained, real-time data and narratives akin to in-person ethnography. Our interviews consisted of both structured and unstructured questionnaires and a household survey.⁸ Islam's existing field contacts among human rights activists in the Rohingya community enabled her to use the snowball sampling method to

6 Islam has extensive research experience through her Wellcome Trust-funded PhD in Bangladesh and is well networked with Rohingya organisations. While all authors are fluent in Bangla, the article draws on Islam's particular linguistic expertise; a native of the city of Chittagong, close to the Rohingya camp in Cox's Bazar district, she is able to understand the Rohingya community and language much better than are most Bangladeshis.

7 This article draws on interviews carried out under the remit of the wider National Science Foundation project (see footnote 8). Ethics clearance was obtained in early July 2020 (IRB reference number: HIRB00011203).

8 The authors gratefully acknowledge the use of a survey template devised by Professor Veena Das and Clara Han as part of their National Science Foundation (NSF)-funded five-country project on decision making in households in the context of COVID-19, with which our own project is linked.

identify and seek informed consent from respondents. Along with ensuring anonymity, confidentiality, and informed consent from the outset of the research, participants were able to opt in to receive a copy of the research. Although the topic is sensitive, the authors are all experienced in this area and took careful consideration throughout of the feelings of the interviewees.

Despite challenges with internet bandwidth, which often made video calling impossible, we found that remote interviews conducted via voice-only calls were remarkably effective. In anthropological as well as other qualitative research, face-to-face interviews have always been given importance as they enable researchers to collect contextual information from participants' surroundings (Holt 2010). We felt this lack of observational contextualisation while we were conducting the interviews over the phone. Walkerdine (1990) shows that the use of the telephone often reduces the intensity of surveillance of the other (Ibid., 195). Holt (2020) found from her experience of researching parents of youths that parents were more relaxed during phone interviews as they were not being judged on the basis of their community, lifestyle, and homes or household settings, which is a possibility in face-to-face interviews. We found similar resonance with our Rohingya interlocutors in our online research settings.

Having conducted an entirely digital ethnography, some reflection is needed on the methodology we chose. The research was based on access via various human rights activists who worked with the Rohingya refugees and were aware of individuals who were willing to speak to us. As a result, the snowballing method generated participants who could speak a bit of English and had mobile devices and internet connectivity. Yet, we were also able to speak with other people who do not have a smartphone through the smartphone of a respondent we had already interviewed. Since the costs of internet data for the purpose of these audio and video interviews were high, we compensated respondents accordingly. Without the possibility of 'being there', what we have often found absent from our writing is the context necessary to 'set the scene' of our participants' lives, since discussion on the digital platform takes a very focused form. It is also significant to distinguish among the refugees and not see them as a homogenous mass. Hence, while everyone in the camp had fled Myanmar, and most will not have brought much in the way of physical resources with them, nonetheless, they all had different symbolic capital which could be used to get by in the camp. That is important for us to record in order to understand the varied predicaments of refugees (including across as well as within locations) and to avoid homogenisation (Mookherjee 2011).

Remote research methods thereby emerged as an adaptive strategy to enable us to keep the qualitative research going during the pandemic, and we found it to be effective (Hinson et al. 2020; Roxana et al. 2020). Furthermore, doing ethnography in person within the context of the COVID-19 pandemic is not feasible from a legal perspective, and remote research methods also protect the health of both researchers and participants (Pacheco-Vega 2020). Thus, aside from being an adaptive strategy for data collection, remote fieldwork in the context of the pandemic is a research method that saves lives as well as time and money.

In the first section of this article we explore the scholarship on trust and mistrust in the light of our anthropological questions. In the section that follows, we highlight the history of the Rohingyas and their trajectory of flight. The subsequent three sections highlight the health services available in the camp, including those relating to COVID-19, along with the role of associated rumours and mistrust. Overall, we show that the anonymity in the crowded Rohingya camps and the mistrust among the Rohingya refugees becomes a form of protection for them from the state and medical authorities they do not trust. This mistrust, we show, is located explicitly in the psychosocial domains of their recent political past of persecution, and is exhibited through their response to the pandemic, taking place in the context of pressures from the Arakan Rohingya Salvation Army (ARSA),⁹ and the Bangladesh and Myanmar governments.

Trust and mistrust: Conceptual reflections

Mistrust has been identified as a 'social failure' and is often seen as being a flipside of trust (Mühlfried 2019). Mistrust creates fear in decision making and sparks 'defensive arrangement', which may increase the potential risk (Ibid., 11) for communities. This focus on the manifestation of mistrust allows us to identify the conceptual basis of trust in this instance. In this light, the complexities of pandemic control and prevention stimulating mistrust must be understood in order to be successfully managed (Brown and Marí Sáez 2020). Various ethnographies gathered by Mühlfried (2019) showed that truth, trust, and mistrust manifest in multiple ways and are entangled with the specific historical and cultural context in which these arise. Truth, trust, and mistrust arise in uncertain situations and continue to exist alongside one other—in times of certainty as well as uncertainty (Ibid.). These ethnographies show that there is no uniform way of demarcating trust and mistrust (idem, 220). We find Yarrow's statement from this volume very

9 ARSA is a Rohingya insurgent group active in the northern Rakhine State of Myanmar, where mostly Muslim Rohingya people have faced persecution. On 25 August 2017, ARSA attacked police posts in northern Rakhine state, killing 12 people. This incident sparked a 'counterattack' from the security forces, causing a massacre of Rohingya.

relevant regarding another intricate aspect of mistrust: '[it] develops through multiple contexts and concerns as ethical and ideological sensitivities, orientations performed through people, material contexts, domestic spaces and institutional cultures of various kinds' (Yarrow 2019, 219).

For instance, Sompore and Sompore (2019) found that during the Ebola epidemic in Guinea, performances of mistrust expressed the needs and claims of the vulnerable and neglected community, whereby both rural and urban people showed their resistance to state-sponsored campaigns for mitigating the spread of Ebola. The Guinean community resisted government initiatives by denying the existence of the disease. In this case, the authors identified mistrust as a mode of engagement with the states and international organisations that community members assumed to be corrupt (Ibid.). Here, it is mistrust rather than disruption to society that engages the community to unite behind a shared experience and common interest (Carey 2017). According to Carey (2017), mistrust empowers people to engage in deliberate action; we show how it can also emerge as a network of protection, anonymity, and security. At this point, we would also like to highlight that the Rohingya mistrust must be understood in the context of a number of pressures: from ARSA presence in the camps; the threats of attack and further displacement by the Myanmar government; and the decision taken by the Bangladeshi government to relocate Rohingya refugees from the camps to the island of Bhashan Char.

Mühlfried further identifies the close entanglements between identity, trust, and 'people's own world':

With the relocation of identity, trust is relocated, too. This leads to a doubling of the world. The world 'out there' is radically distrusted and delimited from one's own world, in which trust is placed, for instance, in the world of the family or the village. The sociologist Charles Tilly refers to these two worlds as 'networks of trust' (Tilly 2005). Often, these networks are based on metaphors of kinship, such as brotherhoods. The new brothers and sisters are united by mutual trust and mistrust towards the environment. Mistrust may thus lead to a displacement of trust (2019, 17).

The doubling of the world is occurring among the Rohingya refugees as they leave their families and/or villages to escape the atrocities in Myanmar. Whether their families are with or without them, the networks of trust of these second worlds are what the refugees come to rely on in the camps. Thus, new kinships are formed, not on the basis of blood relationship or connection by marriage, but within these novel networks of trust. Mistrust is developed and displaces trust, finding a home

in these new networks. Here Putnam's (2001) argument on social capital and social trust might be helpful to consider the significance of mistrust. He argues that the networks of a group or community and its associated norms of mutual exchange have a value which he termed 'social capital' (idem, 1–3). For him, social capital is proportionately related to social trust. Since the 1990s, the concept of social capital has been taken up by a World Bank-initiated community development approach (Grootaer et al. 2002). However, if we follow Putnam's illustration, the limitations of this development rhetoric of social capital become clear. Putnam outlined how the decaying nature of social capital in Louisiana, in the United States, is related to the local history of slavery and of post-slavery reconstruction, which was institutionally designed to prevent community networking, seen as a potential threat to civil society. There are parallels of this formulation in the case of the Rohingya refugees, whose networking and exchange of information can be a threat to the policing of their activities by medical and state authorities. At the same time, it is essential to note that social capital among the Rohingya refugees—who have different socioeconomic backgrounds—is not uniform; as a result, the modes of social trust are also variable. The heterogeneity versus the protection and security of the crowd in the refugee camp might seem to undercut each argument, but this reality of policing persists and sustains the anonymity.

We wish to explore the development of these new networks of 'kinship' around the axis of mistrust among the Rohingya refugees in these crowded camps and in the context of COVID-19. In the process, we identify how mistrust enables the formation of new communities and new networks. What, furthermore, we ask, is the role of social media in emerging as a network of trust that coheres through non-intimate forms of sociality (Broch-Due and Ystanes 2016)? Within this broad framework of trust and mistrust, we argue that the prevailing mistrust among the vulnerable Rohingya refugees is rooted in their long and oppressive political past.

The contested histories of Rohingya refugees

During the Second World War, the term 'refugee' emerged globally as a distinct social, political, and legal concept. It does not mean, however, that there were no refugees prior to this, as people have always sought refuge. In Europe, the Second World War began with a replacement of the old multi-ethnic European empires with the new world order of sovereign nation-states (Malkki 1992). Thousands of people were forced to flee their homes because they did not fulfil the criteria of the nationalist principle of 'one state, one culture' (Gellner 2008). Malkki (1995) notes that refugee camps became a standardised, generalised technology of power towards the end of the Second World War. Through the entire process of mass

displacement, post-war refugees emerged as knowable, nameable figures and objects of social-scientific knowledge. It was increasingly anticipated that, upon post-conflict victories, the masses uprooted during the war would become a problem. Many voluntary agencies like the International Red Cross and Red Crescent Movement started to work and plan for this refugee problem, but looking after refugees was still thought to be the responsibility of the military (in fact, the refugee camps were often modelled on military barracks). In 1951, when the United Nations High Commissioner for Refugees (UNHCR) was established, refugees began to be thought of as an international social or humanitarian problem.

The Universal Declaration of Human Rights was adopted in 1948, as was the Genocide Convention. Since then, refugee law has been an inseparable part of human rights. The principal elements of this law and legal instruments grew out of the aftermath of the war in Europe, which held a strong sense of post-war shame and responsibility for the predicaments of the people who fled their own countries. One of the critical components of this law is providing a legal definition of refugee status. Refugees are often conceptualised as having some essential traits, such as being stateless, unstable, mobile, and suffering from historical and psychological distress (Malkki 1995; Mookherjee 2011). While refugees are 'torn loose from their culture' (Marrus 1985, 8), they do not have a uniform post-traumatic experience or homogenous experience of resettlement in their new countries.

In 2017, following widespread persecution of the Rohingya population by the Myanmar government on the grounds of them having 'illegal citizenship' in the country, a major genocide and mass displacement took place. Instead of using terms like 'exodus', or 'swamping', we use the term 'flight' to capture how Rohingya refugees had to flee Myanmar; more than one million people fled and took shelter in the southern part of Bangladesh. It is important to note that these events were not the result of an overnight conflict—an oppressive history had existed for decades. Rohingyas have been economically oppressed by acting as unpaid forced labour by the Myanmar army in infrastructural projects; through having limited access to viable livelihoods; and through land expropriation by the Myanmar government (Islam 2020; Zarni and Brinham 2017; Leider 2018; Sengupta 2020; Kaveri 2020).

The Rohingyas are predominantly Muslims who live mainly in the northern Arakan state.¹⁰ The language, culture, and religion of the Rohingyas is different from the mainstream Burmese identity of Myanmar. These differences are deemed as the means to exclude Rohingyas from being citizens of Myanmar. Since the British colonial period, Myanmar authorities have been seen to have discriminated against, marginalised, and persecuted the Rohingyas. Rohingya flight thus has a complex and lengthy history. In 1942, Rohingyas were persecuted for the first time by the Buddhist Rakhine. Since then, citizenship has been repeatedly denied to the Rohingyas based on discrimination against their ethnic identity and religion, and the community was instead categorised as 'illegal migrants from Bangladesh' by the Burmese government (now known as the Myanmar government). However, after an intervention from British Prime Minister Lord Atlee in 1947, Rohingyas were given the right to vote (Islam 2020). From 1947, leaders of active political and Muslim religious organisations started demanding to the authorities that the northern Arakan state be made into a separate Muslim zone (Leider 2018). This was denied on grounds of the lack of historical evidence of the existence of Muslim Rohingyas within Burma before its present-day formation. And after the military takeover in 1962 led by General Ne Win, Rohingyas were systematically excluded from the nation-building process.

In 1982 Burmese Prime Minister Ne Win introduced the most oppressive three-tier form of citizenship—citizenship, associate citizenship, and naturalised citizenship—which excluded Rohingyas completely. Under the regime of the Burma Socialist Party (1962–88), state policies provoked more conflict as citizenship became based on ethnic, religious, cultural, and linguistic assimilation. This new citizenship law demanded proof of 'indigenous race'. Those who could not prove such ancestry were not afforded the status of citizens, and this law increased insecurity among Muslims and other non-indigenous populations who were unable to do so. In 1995 UNHCR confirmed that most of the Muslims of Rakhine state could not claim their citizenship under Myanmar's citizenship law (Human Rights Watch Asia 1996).

The Rohingya Muslims also suffered from economic discrimination, targeted harassment, and persecution. A report from Human Rights Watch Asia in 1996 reported that 'they are always ready to flee if there is an option open to them' (Human Rights Watch Asia 1996), and major flights took place in 1978, 1991–92,

10 The Muslim population of diverse origins became known as the Rohingyas; others who are partly of the same ethnic origin but are Buddhist are known as Rakhine. The name of Arakan state was changed to Rakhine state by the Myanmar government in the 1990s, after the name of the majority ethnic group Rakhine. In their conversation, Rohingya refugees often refer to Rakhine state as Arakan state. The feeling of exclusion for the Rohingya minority exists in this naming process, and this can be a reason for not using the name frequently. In contrast, the Arakan state and Arakanese stood for all the ethnic groups living in the region.

2007, 2012, and 2017. Thus, Rohingyas today are scattered throughout Bangladesh, India, Pakistan, Saudi Arabia, Thailand, Indonesia, and Malaysia, with others in the United States, Canada, Australia, the UK, and European countries. With the February 2021 coup by Myanmar's military generals, which followed a general election, Rohingya refugees find their prospect of returning home to be further diminishing (Japan Times 2021).

Burmese human rights activists have argued that the Burmese army, the country's most powerful institution, has since 1966, during the socialist era of General Ne Win, seen Muslims and Rohingyas through the lens of security (Zarni and Brinham 2017). This is a continuation of the colonial legacy of official discourses about the Indian ancestry of Rohingyas, and is embedded in a fear of inter-racial marriage between Burmese women and Indian men, which was depicted as predatory and abusive. Islam (2020, 3) has shown that Rohingyas are a mix of various groups and thus have their own ethnic characteristics, culture, and language. Yet, they are constantly subjected to a reinvention as a group that is being excluded (Leider 2018). However, by referring to Rohingya as 'Jihadi' (Islamic extremist groups), the Myanmar government has viewed them through the same lens of threat and security, and thus legitimised their persecution. This construction of the Rohingya as the enemy 'other' is also based on shifting power dynamics in Myanmar (Chowdhury 2020)—namely, by the religious and exclusivist nationalism propagated by religious civil society and Buddhist Burmese in the post-coup state. As a result, Rohingya victimhood has also been politicised in their search for resilience. Siddiqi (2018) suggests that denationalisation of the Rohingya is not a particularly Burmese problem but rather an extreme version of a contemporary postcolonial predicament experienced by nation-states by virtue of their being nation-states. Despite the restoration of democracy, Siddiqui (Ibid.) finds, no initiative was taken to change existing discriminatory policies against the Rohingyas, which led to the Rohingya genocide. She questions the discovering of the Rohingyas' 'authentic' history and finds problematic the nexus of tying citizenship to ethnicity or indigeneity in terms of ideas of belonging.

While Khatun (2019) shows the Rohingya refugees' resilience in the United States after moving from one country to another, Sengupta (2020) highlights the processes of exclusion, counter-resistance, and self-resilience among the stateless Rohingya refugees through their economic activities in Bangladesh. Lewis (2019) has shown the role of multiple actors in resettling the persecuted Rohingya community, the role of secular and religious gestures by local communities, and the role of charitable and profit-making activities. Bhatia et al. (2018) found that with the absence of formal refugee status Rohingya communities

cannot access full protection.¹¹ This has resulted in a state of insecurity, an uncertain future, unemployment, and a lack of formal education for children. This shows that there is a significant difference in the lives of those with formal refugee status and those without, the latter being constantly policed by the host state—whether in the global north or south. In the next section, we explore how rumour, trust, and vulnerability exist among the Rohingya refugees and their implications for the crowd politics of the camps.

Health services for Rohingya refugees

Trust and mistrust are visibly present in instances when Rohingya refugees are seeking health-related services. In this section, we will present the health service scenario in the Rohingya camp, through which we will identify the coexistence and complexities of mistrust in refugee life. After the major Rohingya influx in 2017, the necessary treatments and services were provided by mobile health facilities operated by both the Government of Bangladesh and by national and international NGOs around the temporary refugee settlements. The Bangladeshi government is unable to be the sole provider of healthcare services to the Rohingya refugees and needs the support of international and national non-governmental health partners. The World Health Organization (WHO), together with the Ministry of Health and Family Welfare (MoHFW) through the Civil Surgeon's office, the Refugee Relief & Repatriation Commissioner (RRRC), and national and international health partners, have thus been working together to offer emergency health services since Rohingya people began crossing the border in 2017. Some local, national, and international NGOs were already working in this area, starting to assist Rohingya refugees as soon as they reached the area using whatever resources they had (Lewis 2019), and their services have continued.

It is noteworthy that NGO participation in the development process in Bangladesh has a long sociocultural and political history. NGOs have played an important role in operating their activities in the country over the 50 years since its independence, working in various less-developed areas such as healthcare, education, reproductive rights and services, and humanitarian relief (Lewis and Hossain 2021). The activities of NGOs have thus become an integral part of development policy in Bangladesh—which is even more the case given the cuts in external development aid in the past few years. Meanwhile, NGOs have become part of civil society, which implies that their social activist, humanitarian, charitable as well as market-oriented services have enhanced their activities in society (Lewis 2014,

11 The Government of Bangladesh officially refers to Rohingya refugees as 'Forcibly Displaced Myanmar Nationals' (FDMN).

2019; Lewis and Gardener 2015). Faith-based international organisations also took part in combating the Rohingya refugee crisis despite the government ban of one such party—the Jamat e Islami party (Lewis 2019)—which stopped the camp activities of other actors seen to be associated with them.

According to the Bangladesh Health Watch report (2020), which offered insights into the health conditions for Rohingya refugees in camps in Bangladesh in 2018–19, 185 health facilities supported the large numbers of refugees in Ukhiya, Teknaf, and Cox's Bazar. Of these, 152 were basic health units, targeting a population of 10,000 people in 2018. Additionally, 25 primary health centres operated round-the-clock and eight hospitals of various functional capacity provided for either 50,000 or 250,000 people. These health facilities are managed mainly by the UN and NGOs yet operate with the approval of the Bangladesh government's Civil Surgeon's office. The health services are intended to provide general healthcare treatment, the management of communicable diseases with the potential for an outbreak (e.g., diphtheria), vaccination, and awareness-building regarding health and hygiene in order to prevent epidemics of disease in the camps. In the initial stage of the COVID-19 pandemic, various campaigns regarding handwashing, social distancing and so on were provided as means of preventing outbreaks in the camps and the wider Bangladeshi community. Unfortunately, many protective measures associated with COVID-19 are not practically possible to follow in the crowded refugee camps, in particular social distancing, which is impossible in such a compact place. Eventually, in April–May 2020, a few months after the outbreak of the COVID-19 pandemic, several hospitals operated by international and national NGOs opened special units and isolation centres in the camps. Over time, the health facilities have expanded their healthcare provision by establishing community clinics, health posts (fixed and mobile), labour rooms, sexual and reproductive health services, infectious diseases treatment facilities (for conditions including diarrhoea, diphtheria, tuberculosis, HIV, and malaria), primary healthcare centres, secondary health facilities, and diagnostic points.

Despite the expanding health facilities, our research found that Rohingya refugees in the camps are not satisfied with the health services provided to them. This dissatisfaction, however, is also evident in the Bangladeshi host community, though in a different context. Dissatisfaction with government-provided health services is profoundly present in public opinion (Bangladesh Health Watch 2015). This disappointment stems from insufficient health supplies; doctors' absenteeism; the presence of *Dalal* (middlemen) in the government hospitals persuading patients to go to private hospitals; and unregulated health sectors causing patients financial suffering (TIB 2018; ASK 2008; 2013; Bangladesh Health Watch 2010).

Although 70% of Bangladeshi people depend on private healthcare, a prevailing perception is that private doctors and private health facilities are overly profit-motivated (*Gola-kata*). This reputation is evidenced by the fact that they are seen to prescribe unnecessary medicines and pathological tests in order to earn commissions from the pharmaceutical companies and diagnostic centres (TIB report 2013, 2018; ASK report 2008; Bangladesh Health Watch 2010). However, the healthcare services which have for decades been provided by NGOs (though delivered in partnership with the government) have proved popular among the community, and have made an active contribution to primary healthcare, vaccination, maternal health, and other programmes within the community (Lewis and Hossain 2021).

To return to the Rohingya people, one of their major complaints is not getting sufficient treatment for chronic diseases like cardiac or kidney disease. As the operation of many health facilities has been limited during the pandemic, with fixed capacities and reduced opening times, people report being unable to see doctors, even after waiting a couple of hours at the hospital. Aside from the healthcare facilities provided by the government and local and international NGOs, Rohingya refugees reported obtaining treatment from three other sources when they are sick. These sources are usually the pharmacy located in the camp, which is run by unregistered Rohingya doctors; traditional healers (*Boidy*); and private healthcare services offered in the Bangladeshi community. The Rohingya refugees prefer to go to the 'unqualified' community doctors (popularly known as *Bogus doctor* or *bhua doctor*). In Rakhine state, not many doctors were permitted the chance to complete their graduate training due to the discriminatory government attitude towards Rohingya people. To mitigate the shortage of qualified doctors, the Myanmar government gave licenses to people who undertook basic training to provide primary healthcare. These non-graduated 'doctors' used to run the pharmacies in Myanmar where they provided treatments. After moving to Bangladesh as refugees, they continued their occupation in the camp, and the refugees have a lot of trust towards these non-graduated doctors.

Like for Mühlfried (2019), here trust is rooted in the therapeutic understanding of Rohingya refugees in their own community, which is embedded in the sociopolitical condition of Rohingya people in Rakhine state. For example, Emdad (a volunteer in a school in the camp) told us that:

Rohingya people have *ador* [affection] for injections. They want quick recovery, which can be 'assured' by a high dose of antibiotics, injection or saline. This practice emerges from the working class Rohingya people, who

could not afford to stay at home without going to work while they were in Arakan [Rakhine] state. Hence, they tend to ask the 'doctor' for a quick recovery: [an] injection or a high dose of medicine. Now it becomes their habit.

Abu Taher (a volunteer in an NGO) echoed this point when we talked about the Rohingya people's dependency on high-dose medicine (biomedicine). In a similar vein, Ahmed, a 32-year-old Rohingya man, who works as a mental health volunteer for an international NGO, said: 'People do not trust the medicine they get from the refugee hospitals. They do not think this medicine will work for them, and these medicines are not as powerful as an injection as these medicines can be bought over the counter'. Abu Taher further narrated that, along with going to the pharmacies, Rohingya refugees also go to the *boidy* (traditional healers) to treat their diseases, which they perceive to be caused by an evil spirit. This is particularly the case in instances of mental illness. When the *boidy* fail to heal the disease caused by the perceived evil spirit, they then go to pharmacies or hospitals.

For severe health conditions, where the necessary treatment is not available in refugee health centres and hospitals, doctors refer patients to hospitals with better facilities, outside the camp. Often, those refugees with greater resources prefer to go to private healthcare facilities. However, as well as a referral from the camp hospitals they require permission to leave the camp, which is not easy to obtain. Before the flight of the Rohingya refugees in 2017, many within the Rohingya communities with access to resources would travel to Bangladesh to use Bangladeshi private healthcare, which they are no longer able to do. The closure of this possibility has made them upset. Abu Taher, 33 years old, told us that many Rohingya individuals who could afford it had been under the treatment of private doctors for many years before arriving in Bangladesh as refugees, and were formerly able to access extensive testing and treatments. Now, many of them are continuing to take medicines initially prescribed by the Bangladeshi private doctors without following up, as they can no longer go to them for treatment. If they ask refugee hospitals for follow-up treatments or check-ups, they do not get the services they want. Refugee hospitals offer very basic treatments, a few common medicines, and almost no testing. Since they are not getting the treatment they want, many refugees with chronic diseases are dissatisfied and report feeling deprived.

The coexistence of trust and mistrust is evident from Abu Taher's conviction about the emergency healthcare on offer. He told how: 'we really get excellent emergency care, such as if anyone broke his leg or something like that. We even

get better primary care, like if anyone has body ache, headache, or fever'. At the same time, Abu's mistrust reared its head when he questioned why the treatment for chronic diseases like problems of the kidney, heart, or liver feels like a 'useless', fruitless exercise on the part of authorities; it is only very recently, for instance, that the hospital has started treating hepatitis. Abu narrated how his 65-year-old father, who has multiple chronic diseases, got permission for treatment when the refugee hospital referred him at last to the Cox's Bazar hospital, outside the camp. With great difficulty, he managed to obtain permission from the *majhi* (camp leader) to leave the camp for the treatment.

In 2019, Ahmed's one-year-old son had pneumonia, and the NGO hospital could not treat him. So Ahmed arranged to take his son to a private hospital in Chittagong with the help of friends. By contrast, Ahmed's mother cannot continue with treatment relating to her kidney removal surgery, which also took place in Chittagong, five years before the family were forced to flee Myanmar, because she cannot get the treatment she needs from the hospital near their camp. Another big hospital in another camp might be able to offer her follow-up treatment but the family cannot take advantage of this because ARSA controls that camp area. This is another internal political issue that also affects refugees' lives in the camp. Although by fleeing to Bangladesh, Rohingya people were able to escape from the Burmese army, ARSA has become a new threat. Hence, Ahmed buys medicine for his mother from the pharmacy outside the camp, using the old prescription, and takes advice about her treatment from his doctor friend. He is also very annoyed and worried about the Bangladesh government's decisions about vaccinating children in the camp. Both of his children were already vaccinated against diphtheria and he did not want his children to get vaccinated a second time as he was concerned about the side effects. Despite his children having a vaccine card from Rakhine state, those in charge of vaccination did not accept the card as proof of their previous vaccination, and Ahmed had no choice but to accept that, in line with the government's rules, his children must again be vaccinated.

Another poignant account of the coexistence of trust and mistrust was highlighted when Emdad, the NGO volunteer, put us in touch with Mahmudur, who owned a small shop in the camp selling candies, cookies, snacks, and betel leaf (*paan*). In talking about his feelings about the medical services in the camp, he immediately turned to the instance of his wife's recent death. Mahmudur narrated that in October 2020, his wife had died 17 days after giving birth to their fourth child by emergency C-section. Mahmudur's wife was discharged from the hospital on the fifth day but was taken back to the hospital after she started having severe stomach pain. The hospital sent her back home with some medicine, which did not cure her

pain. Then Mahmudur and his wife sought treatment from their own community doctors. Mahmudur did not take her back to the hospital, despite her worsening condition, since the hospital had not done anything for her stomach pain when she was there. Instead, he trusted their own community doctor over the hospital, as he believed the hospital would not cure his wife.

Rohingya communities are also accused of selling the medicine they get from hospitals. They are perceived to go to the hospital to get medication so that they can sell it, while actually taking treatment from their trusted community doctors. However, this accusation was denied by Lwing Naing, the young activist with whom we started this article. He told us, 'the accusation should not be generalised to all refugee people. Maybe very few people sell medicine to buy their food. We get basic food supplies from NGOs, but we have to buy vegetables and other stuff that [you] need money to buy'.

In each of these instances, we see an interplay of trust and mistrust. Mistrust towards the medical services is a means of protecting oneself from the authorities, who are deemed to have failed refugees already, like in the case of Mahmudur. Mistrust is seen in the attitude towards medicines being provided, which are deemed to be 'useless', like in the case of Abu Taher's father. Instead of relying on camp medical services, Rohingya refugees would rather use their community doctors, and the new networks and kinships that they have developed in the camps.

COVID-19 in the refugee camps

Lockdown (announced as a form of 'national holidays') was declared in Bangladesh on 25 March 2020. Besides its health impacts, COVID-19 has brought uncertainty in many ways to people's lives across society and culture. During the pandemic, accessing medical treatment became difficult and uncertain, which also triggered fear,¹² rumour, and misinformation about COVID-19. The pandemic has also affected the Rohingya people living in the refugee camps in many different ways.

The Government of Bangladesh had in September 2019 restricted internet and mobile networks in the camps on security grounds (HRW 2020),¹³ although the

12 Various anthropologists have explained fear not merely as an individual's response to the danger, but also as collective feelings that remain in social memories, and structure individuals' daily lives (Kleinman, Das, and Lock 1997; Das 2020; Scheper-Hughes 1992; Green 1994, 1998).

13 The Bangladeshi government, like that of many countries in the world, uses a 'digital fog' (see Mookherjee and Lacy 2020) to disrupt internet access, making it harder to circulate and access images and information. It also uses its

nature of the potential risk of having an internet connection in the camps has not been clarified by the authorities. While internet-based information became an essential source of knowledge about COVID-19, the internet blackout and mobile network restrictions prevented millions of people from getting health information. This government decision also risked the health and lives of over a million people by obstructing emergency health services and the coordination of essential preventive measures. Ahmed told us:

By the internet blackout, our access to health information was denied. We failed to contact our sick relatives who were in a different camp. In the early days of the pandemic, internet sources played a pivotal role in restoring our courage. We have many friends and relatives around the world. For those who are traumatised by the persecution, staying in contact with family and friends [is] crucial to their lives.

These attempts to disconnect them from the world and the rest of the community is a way of silencing the Rohingya refugees. Ahmed added, 'We do not know about corona[virus] infection rate in the camp. Now government restores the internet, but the bandwidth is still [too] low to establish a proper connection'. He went on anxiously, 'I don't know what else they will do with us after that'. A profound mistrust towards the Bangladeshi government is evident in Ahmed's statement. His expression about deprivation and silencing is related to the Myanmar government's coercive nature. At the same time, Bangladesh as 'host' has also decided on an internet blackout as its own security measure. Ahmed, like his fellow refugees, conflates the experiences. Hence mistrust, rumours, fear, and vulnerabilities are felt by the Rohingya refugees at the intersection of the Myanmar government's coercion and the Bangladeshi government's decision over internet blackout. These feelings are also in evidence, more recently, in relation to refugees' further displacement to the island of Bhashan Char by the Bangladeshi government. In December 2020, the Bangladeshi government started relocating Rohingya refugees to this isolated, low-lying island, which is prone to cyclones and floods, as part of what is thought to be a 'long term solution' to the refugee crisis (Bhuiyan 2020).

Here it is important to note that fear, stigma, and lack of trust in health authorities during the COVID-19 pandemic have also been documented among the 'native' Bangladeshi population. This is particularly linked to the government's draconian

Digital Security Act to control online behaviour related to comments linked to the 'image of the state', among other concerns. See Human Rights Watch (2020).

Digital Security Act (Mookherjee and Lacy 2020) and its implementation during COVID-19, which has led to numerous arrests, incarceration and death (see Rabbit 2020; Bdnews24 2021). Ahmed's palpable fear about what further action the government might take, however, highlights the particular vulnerability of the Rohingya community, which is distinct from that of native Bangladeshis. Here the Rohingya communities are ensconced between the genocidal persecution of the Myanmar government, the humanitarian policing of the Bangladeshi government (including marginalising them to Bhashan Char), and a global pandemic whose reach threatens their proximate living in the camps. Moreover, with the February 2021 coup by Myanmar's military generals, Rohingya refugees' prospects of returning home are also diminishing, and they continue to be dependent on the Bangladeshi authorities. It is their recent and ongoing political experience that makes their fear and mistrust of a different intensity to the experiences of 'native' Bangladeshis.

The lives of Rohingya refugees, whose daily sustenance and activities mostly depended on national and international humanitarian aid, were initially disrupted by the pandemic as the normal way of life was completely shut down. Aid workers were compelled to reduce their usual activities and services in camps, and donor agencies also restricted their activities in order to protect service providers' health and security. Yet, forms of mistrust and rumour persisted despite the awareness initiatives taken by the government and international NGOs to prevent and manage the pandemic spreading in the camps.

Forms of rumour and mistrust

With great disappointment, Ahmed told us that his father-in-law does not believe in the spread of SARS-CoV-2, thinks it does not infect Muslim people, and is an invention by foreigners. Furthermore, he thinks that every year, flu-like diseases spread in the community. For those with weak health, their condition gets worse or even fatal. Ahmed thinks that many people in the camp and in Bangladesh, like his father-in-law, do not believe in COVID-19 because of ignorance. He also added an explanation of this community attitude:

[A]ctually, they do not have any other choice but deny the coronavirus, as they are unable to follow the restrictions. We live in a crowded place, and we must go out for work. We cannot maintain social distance by staying at home. If we do so, we will die not of coronavirus but hunger. So, people deny the facts of coronavirus. By denying, they accept the reality of their incapacity to follow the social distancing restrictions.

It is interesting to see how rumour is justified and becomes part of coping strategies, as evidenced through Ahmed's narratives. In a similar line of argument, anthropologists have long analysed the relationship between rumour, scepticism, and politics from local to global levels (Armstrong 2016; Feldman-Savelsberg, Ndonko, and Yang 2017; Firth 1956; Perice 1997; Renne 2010). However, we also found that Rohingya refugees strategise to combat the virus by drinking warm water and tea with spices. Sompore and Sompore (2019) similarly found that amidst rumour and mistrust, the health preventive measures undertaken by Guinean people against the Ebola virus were based on traditional practices, alongside biomedical measures.

On the other hand, Nasrullah, a Bangladeshi man who works for an international NGO-run hospital, told us:

We do not get corona[virus] suspected patients despite volunteers and health workers making door-to-door visits in the camps. We had to take information from the *Majhi* [camp leader] if anyone had corona[virus] symptoms. We found a multi-layer of fear, mistrust, and rumour omnipresent in camps that prevent them from going to hospitals even for the non-COVID related diseases.

Here Yarrow's statement on mistrust seems instructive: 'Mistrust develops through multiple contexts and concerns as ethical and ideological sensitivities, orientations performed through people, material contexts, domestic spaces and institutional cultures of various kinds' (2019, 219). Extending this observation to the Rohingya refugees, we find that their mistrust is located explicitly in their recent and ongoing political pasts and present psychosocial domains, and it is exhibited through their response to the pandemic.

Rohingya refugees are suspicious of the health service providers and worry that if they are admitted to the hospitals for COVID-19 infection, doctors will kill them to stop them spreading the virus; being refugees, they also believe themselves to be considered easily dispensable by various authorities. MSF (2020) has documented similar findings. Various researchers have found comparable discourses of mistrust towards health providers during the West African Ebola epidemic of 2013–16, who were believed to have killed infected patients to prevent the spread of the disease (Brown and Marí Sáez 2020; Mühlfried 2019; Ali 2020). The perceived biomedical control over the body and lack of understanding of the new contagious disease might be the root of mistrust in the healthcare providers during the epidemic. Moreover, the strict separation of the therapeutic infrastructure during the pandemic creates a dramatic situation in people's minds, contributing to

mistrust and fear (Brown and Marí Sáez 2020). As a result, the separation of the isolation unit is a geographical, physical, and emotional separation that the refugees greatly fear.

Emdad told us that it is not always mistrust that prevents Rohingya people from accepting treatment for COVID-19 in the isolation centre, despite the offer of food and shelter for the patient's whole family during the mandated period of isolation. He said: 'from April–July [2020], we all had flu-like symptoms. But we did not go to the hospital. We took care of ourselves, and we bought medicine from the shop [over the counter]. One of the reasons is they [camp residents] cannot accept the detachment from the family.' Furthermore, the isolation unit might not be considered 'safe' since isolation was considered to further stigmatise individuals and families for being infected. Besides, respondents heard information from various sources about the isolation centre, which made them doubtful about doctors' and other healthcare providers' efficiency, since they were reported to maintain distance and did not touch patients. As Brown and Marí Sáez (2020) rightly point out, 'understandings of trust are a helpful entry point for making sense of how people developed and interpreted different forms of separation during the epidemic' (13). The fear of separation stems from the violent political experience of forceful displacement and mass killing and, due to the embedded fear and lack of trust, many Rohingya refugees reject the offered treatment and take an active stand against what they perceive as others taking advantage of their vulnerability.

Other rumours exist in the camps: that the refugees in general as well as the infected patients will be handed over to the ARSA, who will kill them, or they will be relocated to Bhashan Char. Their fear and mistrust in the health services are rooted in the political context of their flight, which increases their vulnerabilities. Lwing Naing's observation about 'medicine in name only' highlights not only the mistrust of the Rohingya refugees but also shows the futility of the health service because of its inadequate understanding of the political context of the Rohingya refugee situation. By avoiding or denying the health service, Rohingya refugees show their resistance to the system, which they find threatening to their existence. At the same time, however, mistrust also enables them to inhabit a zone of protection. As a result, they can avoid being in the spacious, new isolation centres and instead protect themselves within their networks in the anonymous, crowded spaces of the camp.

Conclusion

There is nothing that man fears more than the touch of the unknown.
(Canetti 1962, 15)

Elias Canetti's chapter on 'the fear of being touched' by the unknown and strange crowd does impart the potentiality of danger from the effervescence of the crowd alongside its radical and equalising possibilities (Canetti 1962). Canetti's dictum about the fear of the touch of the unknown, of the crowd as a source of fear, has been extended under COVID-19 to the known. The pandemic has made us fearful of the touch of the familiar, as it is unknown what others might have touched which can lead to the transmission of the virus. Hence crowds and the possibilities of proximity and touch are anathema and a source of fear in the context of the pandemic. Yet, the crowd has become the site of production of trust for Rohingya refugees amidst the fear of contagion. Crowds have long been considered to be without power and opposition to 'the people'—the latter standing in for connotations and ideas of democracy. Yet the crowd's vitality, with its limited freedom, is increasingly deemed to be a possible unit of politics (Chowdhury 2019). In her book *Paradoxes of the Popular: Crowd Politics in Bangladesh*, Nusrat Chowdhury shows how protesting crowds have been the site of resistance, a space of meaningful change in the democratic culture of Bangladesh, as in many other places (idem, 8). Their potentialities, she shows, could be mobilised by those in power and their opponents.

Unlike Chowdhury's (2019) formulation, the overcrowded Rohingya communities in the camp are not a mob nor a political mass with direct democratic potential. But in their capacious configurations, they are different entities. The Rohingya crowds show how protection and resistance are closely intertwined in the proximate inhabitation of camp life and its vulnerabilities. The paradox of the crowded camp as the source of protection and resistance on the part of the Rohingya communities—which is manifested as mistrust in healthcare services—makes us reflect on the varied conundrums relating to the relationships between trust, separation, and touch. Scholars Brown and Marí Sáez (2020) have reminded us of the varied connotations of separation in the context of the pandemic. Mistrust and fear are not only generated among the Rohingya refugees by the geographical, physical, and emotional separation of the therapeutic units. They are also intertwined with the past and ongoing displacement that they have been and are being subjected to by the Myanmar and Bangladeshi governments. In these zones of separation, with the camp as the penultimate and visible zone of separation, the fear of touch of the unknown and the known has generated further

vulnerability among the Rohingya communities. As a result, we see new networks of kinship developing through online spheres where proximity, intimacy, and touch are enabled through screens without the fear of contagion. As a result, the internet blackouts feel like such an existential threat, as expressed by Ahmed's fearful speculation about what might happen to them next. Here, 'next' stands in for the palpable and visceral sense of fear, mistrust, and vulnerability among the Rohingya communities. The crowded camp and its lack of space, on the other hand, becomes the zone of anonymity, protection, and resistance among the Rohingya communities.

In the midst of keeping ourselves away from the socialities of touch, our article has explored how the fear of the spread of the SARS-CoV-2 virus has impacted the proximate lives of the Rohingya refugees in the crowded camps. Bangladesh has been lauded by the international community for giving a home to the refugees, and this welcoming stance has been linked to Bangladesh's experience of its own people having been refugees during the 1971 war (Lewis 2019). Hence, Bangladeshis are deemed to have empathy for the conditions of the Rohingya refugees fleeing genocidal attacks by the Myanmar government. However, the presence of the Rohingya refugees in the southeast corner of Bangladesh has led to a tinderbox of conflict with the locals, and many rumours circulate about the Rohingya refugees. Hence as a source of displacement and refugee politics, the Rohingya refugees have been the nemesis of many Bangladeshi people, including those in the activist communities in the democratic and public life of the 'host' country.

The rumours and negative views about the Rohingya refugees are also evident in the response of the Rohingya communities to their circumstances within the context of COVID-19. Rather than seeking out the facilities of the spacious, clean isolation centres with their provision of food and medicine, Rohingya communities have preferred to stay in their crowded camp with their shared bathrooms and proximate conditions. Following Chowdhury (2019), crowds are a site of resistance, and we would extend this argument further to say the crowds of the camp are a source of protection for the Rohingya refugees who do not trust the medical and government facilities within the camp. In thinking through Canetti's (1962) contention that crowds allow for collective joy to be experienced as transcendental, and that being part of one submerges our individual failings (see Satyogi and Saria's introduction to this special section), we also want to highlight the role of anonymity as a source of security and strength for the Rohingya refugees. As a result, they continue to stay within their crowded facilities as this

crowd is a source of defence and security for them against the technologies of medical governance, which may, they fear, deem them dispensable.

Above all, the crowded camp is also a source of protection and information in the face of constant disruption to the Rohingya refugees' 'virtual streets' (Mookherjee and Lacy 2020, 285–86): in other words, the interruption of their online access by the government authorities. As a result, when digital access is disrupted in the camps, Rohingya refugees develop networks of trust offline, and these then become the trusted online sources, even if they are from those beyond their immediate families. Certain offline and online sources are thus vital manifestations of trust that cohere through non-intimate forms of sociality (Broch-Due et al. 2016). Therefore, as new kinships are formed within these novel networks of trust, the development of mistrust displaces trust and finds its home in these new networks. In the process, we identify how mistrust and crowds both emerge as sources of strength, protection, and security among the Rohingya refugees.

In this article, we have argued that for the Rohingya refugees mistrust is not the opposite of or negation of trust but is instead a form of protection within a perceived hostile context. We argued that Rohingya refugees' response to the COVID-19 pandemic is located in their unstable post-genocide traumatic context and is thus conditioned by their oppressive past. The manifestations of mistrust among the Rohingya refugees are also a perception of their futures amidst their vulnerabilities to genocidal persecution by the Myanmar government and animosity from the Bangladeshi communities. This is alarming given that, as of 3 October 2021, 3084 confirmed cases and 32 deaths had been reported in the Rohingya refugee camps (WHO Rohingya Crisis Situation Report, 2021). It is of critical significance to understand why medical facilities set up for COVID-19 affected Rohingya refugees remain almost empty.

While states provide support for refugees on humanitarian grounds or under geopolitical pressure (Ong 2003), we have argued that mistrust among the Rohingya refugees living in the world's largest camp in Kutupalong can only be understood through their individuated life trajectories and politics in the context of their history of systemic and ongoing oppression. While deemed to be non-cooperative in terms of their resistance to the policed health facilities in the context of COVID-19, the paranoia of the Rohingya 'crowd politics' (Chowdhury 2019) highlights their attempt to communicate with a global public (Canetti 1962), in the context of Bangladesh and a continued statelessness engendered by the Myanmar government.

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