IN THE SHADOWS OF THE PANDEMIC: THE GENDERED IMPACT OF COVID-19 ON ROHINGYA AND HOST COMMUNITIES

October 2020

Acknowledgements

Cover photo: 65 years old Laila Begum* with her husband Abu Baker Siddiki* (*names changed to protect identity) are sitting idly inside her tent as she is informed to stay inside house since COVID-19 outbreak in the camp. Rohingya refugee Camp, Cox's Bazar, Bangladesh. Photo Credit: Fabeha Monir/ Oxfam.

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Acronyms

CBO	Community-based organization
CiC	Camp-in-Charge
COVID-19	Novel coronavirus 2019
CPJ	Centre for Peace and Justice
GBV	Gender-based violence
IPV	Intimate partner violence
ISCG	Inter-Sector Coordination Group
KII	Key informant interview
MHM	Menstrual hygiene management
PPE	Personal protective equipment
RGA	Rapid gender analysis
PWD	Person with disability
RRRC	Refugee, Relief and Repatriation Commission
WASH	Water, Sanitation and Hygiene

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EXECUTIVE SUMMARY

Since the onset of global COVID-19 pandemic in December, Bangladesh has been in a state of high alert. The first confirmed case of COVID-19 in Bangladesh was recorded on 8 March 2020. By 26 March, containment measures were implemented, impacting an already vulnerable population. As of 13 September there have been 337,520 total cases, with 4,401 in Cox's Bazar and 179 across all 34 refugee camps.[1] However, it is highly likely that these low case numbers are more indicative of negligible testing than of the actual spread of the virus; the true incidence of the disease is unknown.[2] COVID-19 and the accompanying containment measures have had a significant impact on women, girls, men and boys, including female sex workers, transgender persons and people with disabilities, across all camps, exacerbating existing conditions, such as overcrowding, movement across hilly terrain, uneven access to a limited number of WASH and health facilities and inadequate access to protection and hygiene resources. This has hindered the ability of refugees to take the necessary preventive measures to limit infections. The host community faces similar difficulties, and, moreover, the containment measures had an adverse economic impact on both host and refugee communities.

This Rapid Gender Analysis (RGA) builds on the secondary data analysis done in May 2020 by the Gender Hub, UN Women, CARE and OXFAM. This RGA aims to answer the following research questions:

- How has COVID-19 impacted women, girls, men and boys and key vulnerable and marginalised groups' ability to meet their basic needs and entitlements?

- What achievements made on gender equality and the empowerment of women, girls and LGBTQ+ groups are now at risk of being undone by COVID-19?

- What new or heightened protection and safety risks are arising from COVID-19?

- How can women, girls, men and boys, and key vulnerable and marginalised groups participate and lead in the COVID-19 response?

The research was conducted using primary data collected in Rohingya and host communities in Cox's Bazar between 15 June and 9 July 2020 to understand the impact COVID-19 has had on age, gender and other social characteristics, and to analyse how the socio-cultural context helps or hinders people's ability to cope with the crisis. The purpose is to generate evidence to support the design of gender-responsive intervention/strategies for the COVID-19 response in Cox's Bazar that can be used for advocacy and fundraising purposes.

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1   World Health Organization, "*Rohingya Crisis Situation Report #20*", 26 August 2020.

2   ACAPS-NPM Analysis Hub, *"COVID-19 & Secondary Impacts Cox's Bazar"*, 5 July 2020.; ACAPS-NPM Analysis Hub, IOM, *"COVID-19 Explained, Edition 7"*, 13 July 2020.

The study findings show that gender norms and roles have barely changed during the pandemic, with decision-making power still firmly controlled by men and tied directly to income generation. COVID-19 may have a negative impact on how women and girls negotiate the restrictive social norms that govern their lives, given that COVID-19 has further restricted their mobility in public spaces, confining them further to their homes, and also increasing social stigma and GBV in all forms.

The key findings based on the key sectors and working group of Communicating with Communities, Education, Food Security, Health, Protection and Water, Sanitation, and Hygiene (WASH) are presented in the infographic below, and further detailed alongside sector and working group specific recommendations in part three.

Fatuma (name changed to protect identity has her temperature taken at a CARE health facility in the Camp during COVID-19 pandemic. Photo credit: Asafuzzaman Captain.

OVERALL FINDINGS

- Gender norms and roles have barely changed during the pandemic; decision-making power is still firmly controlled by men. This can limit the ability of women and girls to make critical lifesaving choices around COVID-19. Most women who reported not being able to make their own health or purchasing decisions said they need their husbands' approval.

- The burden of unpaid care work has increased due to COVID-19 prevention measures and it remains almost exclusively the responsibility of women and girls.

- Achievements that have been made towards gender equality risk being undone as access to services and entitlements have been greatly reduced, and as there is significant potential backlash against women, transgender persons, and other vulnerable groups such as sex workers based on social and religious norms, rumours, and social stigmatization.

- Rohingya women were reported to be less able to make decisions on their own than host community women.

HEALTH

- Increased difficulties accessing health services during the pandemic, with distrust, dissatisfaction and misinformation hindering health seeking behaviours.

- Women, children, transgender persons and persons with disability all face more barriers in accessing health services.

- Access to crucial services such as sexual, reproductive, and maternal health services are reduced.

- There is an increase in mental health issues, sense of insecurity and stress across the board, and in particular with men and boys.

- Previous work on protecting and empowering women and girls has been disrupted, making it harder to access services like MHM, sexual reproductive health, protection, women and girl friendly spaces, and access to justice for GBV survivors because such services and activities were deemed non-essential.

PROTECTION

- Safety and security risks have increased during the pandemic for everyone, but pre-existing gendered risks are exacerbated.

- Gender-based violence is increasing, including IPV, polygamy, transphobic violence, and violence against female sex workers, while access to support is more restricted.

- There is an increase in forced/child marriage, a halt in education and livelihood services, reduced access to women and girls' spaces, and a lower presence of camp authorities.

- Children and adolescents are likely to experience negative impacts on their mental health due to the loss of educational opportunities.

- There is increased stigma against transgender persons who due to existing social discrimination and a tendency to blame perceived outsiders for spreading the virus.

COMMUNICATION WITH COMMUNITIES

- COVID-19 prevention measures were mostly known and understood but following them was challenging.
- Gender norms and roles create differences in maintaining preventative measures and women and girls, men and boys, are at risk of exposure to COVID-19 in different ways.
- Rohingya refugees both prefer and rely on information that is provided by people. Women prefer door-to-door visits, men prefer loudspeaker announcements.
- Host communities prefer to receive information through television.

EDUCATION

- Lack of access to education for children is a concern for both the Rohingya and the host community.
- Pre-existing gender bias for boys' education is likely to be exacerbating with new schooling arrangements.

FOOD SECURITY

- Rohingya refugees and host communities face overwhelming difficulty accessing sufficient food, particularly single mothers, households headed by persons with disability, pregnant and lactating women, elderly persons, and children.
- The economic consequences of the pandemic have been one of the biggest impacts on both communities.
- Women, who are mostly engaged in the informal economy, and vulnerable groups dependent on daily work, such as persons with disabilities, transgender persons, and sex workers, have been hit the hardest.

WASH

- Difficulty accessing WASH services has increased amongst Rohingya refugees due to a lack of water storage systems and containers, distance, wait times at water points, and delays in WASH services.
- Women and girls face issues of overcrowding and lack of privacy when using latrines during the day, while at night they risk of harassment and violence due to inadequate lighting.
- MHM has become more difficult during the pandemic due to delays in distribution of materials and increased difficulty for women and girls to wash and dry their menstrual cloths due to taboos around menstruation, resulting in increased risk of infection.
- The host community by and large does not face such problems.

OVERALL RECOMMENDATIONS FOR ALL STAKEHOLDERS ENGAGED IN THE RESPONSE

A. Women's leadership and active engagement is essential, in particular underrepresented and marginalized groups, such as persons with disabilities, older people, adolescent girls, transgender persons and female sex workers, in all aspects of the COVID-19 response.

1. Consult with women, girls and transgender persons in Rohingya and host communities regularly and explore ways to better promote their meaningful decision-making and leadership roles in the planning and implementation of COVID-19 preparedness and response activities. Consultation and engagement need to be carried out in a gender-sensitive manner, by female volunteers and staff and in women-only settings, providing respondents with sufficient information to make informed decisions.

2. Systematically engage women and female youth volunteers, women leaders and women's and LGBTQ+ networks to identify, reach out to and support at-risk women and adolescent girls.

3. Include underrepresented and marginalized groups by actively seeking out their opinions and specific needs and entitlements.

B. Differing needs and entitlements of women, girls, men and boys, LGBTQ+ populations and key vulnerable and marginalized groups must be addressed at all stages of the COVID-19 response.

4. COVID-19 prevention and response activities, community engagement and messaging must be designed to mitigate and take into account gender issues, in line with sector and working group-specific recommendations outlined in this report.

5. Increase the number of female volunteers and frontline workers to improve the gender balance and equally reach women and girls in the sharing of information and service provision in a socio-culturally appropriate and gender-segregated way. Build the capacity of all service providers, especially in health, to ensure the delivery of services without discrimination and judgment. This should include training on gender equality and addressing provider biases, including transphobic behaviours and attitudes. All women frontline workers have sufficient information, services and tools to protect themselves and their families.

6. Develop and monitor specific gender indicators in the preparedness and response plans of all sectors to assess the impact, trends and reach of the interventions.

7. Collect and analyse sex, age and diversity disaggregated data on COVID-19 infection rates and prevention and response activities. To the extent possible, following do no harm principles and ensuring privacy, data on diversity should include disability status, individuals identifying themselves as transgender and the identification of other vulnerable characteristics (i.e. engaged in sex work).

8. Regularly conduct sector- and location-specific gender analysis to understand the differentiated impact of COVID-19 on women, girls, men and boys and other vulnerable groups.

C. Mitigate and respond to new and increased risks arising from COVID-19 faced by women, girls, men and boys, and key vulnerable and marginalized groups.

9. Prepare for, mitigate, and respond to any potential backlash against women, transgender persons and female sex workers based on social and religious norms, rumours, and social stigmatization, including through engagement with religious leaders, women leaders, civil society organizations representing vulnerable and marginalized groups and communities overall.

10. Advocate for essential services that have been deprioritized in the COVID-19 response (for example, protection services, GBV services for survivors, sexual reproductive health services, menstrual hygiene management, drop-in-centres for female sex workers, women's leadership programming and initiatives, income-generating and self-reliance activities and education) to be reassessed and re-established as soon as possible, taking into account safety measures.

1 INTRODUCTION

1.1 Country Context: COVID-19

Since December 2019, the Novel Coronavirus 2019 (COVID-19) has infected almost 29 million people globally, resulting in more than 991,224 deaths at the time of publication.[3] The virus was officially confirmed in Bangladesh on 8 March 2020, with cases totalling 357,873 as of 27 September 2020.[4] In Cox's Bazar, home to 860,697 Rohingya refugees in addition to the host population, initial cases were confirmed on 23 March, with a total of 4,721 cases by 27 September 2020.[5] Enforced access and movement restrictions to the 34 refugee camps temporarily delayed its spread into the camps, but cases were officially confirmed in the camps on 14 April. As of September 27, 2020, there has been 251 confirmed cases across almost all camps (73% male, 27% female), resulting in eight deaths (37% male, 63% female).[6] Actual infections and the death toll are likely to be higher.

COVID-19 has had a significant impact on the Rohingya refugees living in the 34 extremely congested camps in Cox's Bazar. The overcrowded conditions, hilly terrain, uneven access to limited number of WASH and health facilities, and an insufficient amount of protective and hygiene items have hindered the Rohingya population's ability to follow the preventive measures necessary to limit infections. The host communities living near the camps also face challenges in protecting themselves from the virus, and the containment measures taken by the government are likely going to have further adverse economic impacts on these communities.[7]

Worldwide, the socioeconomic impact of COVID-19 has been well documented, including from a gender perspective. Differences in infection rates and adverse health effects have been noted between sexes and genders, in some cases due to social norms that impact upon mobility, access to public spaces, health care seeking tendencies and the burden of care work. The virus' socioeconomic impact, both short- and long- term, also differs widely based on gender and other social characteristics. Gender-based violence (GBV), particularly violence against women, girls, female sex workers and transgender persons, has increased globally due to COVID-19 and the related containment measures.

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3   World Health Organization, *"WHO Coronavirus Disease (COVID-19) Dashboard"*, 27 September 2020.

4   World Health Organization, *"Coronavirus disease (COVID-19) Situation Report: Cox's Bazar Level Update"*, 27 September 2020.

5   UNHCR and Government of Bangladesh, *"UNHCR Population Factsheet",* 31 August 2020.; World Health Organization, *"Coronavirus disease (COVID-19) Situation Report: Cox's Bazar Level Update"*, 13 September 2020.

6   World Health Organization, *"Coronavirus disease (COVID-19) Situation Report: Cox's Bazar Level Update"*, 13 September 2020.

7   Inter-Sector Coordination Group, *"Covid-19 Response Plan: Addendum to the Joint Response Plan 2020 - Rohingya Humanitarian Crisis (April - December 2020)"*.

Isolation, quarantine, and confinement has forced many GBV survivors to stay in the same location as their perpetrators, with little access to services and support. The closure of schools and childcare services has resulted in many women and girls taking on more of the unpaid care work at home. As women also make up more than two-thirds of the health workforce globally, and women generally take on caring roles at home for elderly or sick relatives, they are disproportionately at risk of infection[8]. These are only some of the examples of how COVID-19 affects different populations to varying degrees. Socio-cultural contexts, including gender norms and roles, play an important role in how different groups can prepare and protect themselves from COVID-19, and how they recover from it.

1.2   Purpose of Rapid Gender Analysis

Without a robust understanding of socio-cultural contexts, including gender norms and roles, programming within the COVID-19 response will be less effective and inclusive than it should be. This was already observed during the planning of mixed-gender isolation facilities. An understanding of social norms and gender dynamics shows the importance of designing gender-segregated facilities because women would have limited access to mixed facilities, resulting in a low disclosure of cases. This was confirmed through the consultations led by the Communicating with Communities Working Group, where women reported feeling uncomfortable or unsafe accessing mixed facilities and with men refusing to allow female relatives to access these facilities alone because of the presence of unknown men. Previous gender studies show that this affects the honour of these women and their families. This is likely to exacerbate the stigma that is already associated with the disease.[9]

The RGA aims to understand the different impacts COVID-19 has had on age, gender and other social characteristics, as well as to analyse how the socio-cultural context will help or hinder people's ability to cope with the crisis. To that end, the objectives of the RGA are:

- To identify the knowledge, attitude, practices and other socio-cultural determinants and drivers of COVID-19 transmission from gender, age and other diversities perspectives.

- To identify the impact of COVID-19 on pre-existing structural, social, and economic vulnerabilities from gender, age and other diversities perspectives, including equal access to services.

- To identify the various coping mechanisms adopted by different social groups during the COVID-19.

- To generate evidence to support the design of gender-responsive interventions/ strategies for the COVID-19 response that can be used for advocacy and fund-raising purposes.

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8   UN Women, *COVID-19 Bangladesh: Rapid Gender Analysis*, 2020.

9   International Organization for Migration IOM and UN Women, "*Honour in Transition: Changing Gender Norms Among the Rohingya*", April 2020.

The RGA builds on its previous iteration, published in May 2020 by CARE, the Gender Hub, Oxfam and UN Women, which was developed following a review and analysis of secondary data. This document uses primary data collected in Rohingya and host communities to validate the assumptions made in the previous version, to fill information gaps and to provide evidence for gender-responsive programming during the COVID-19 crisis.

1.3 Methodology

The RGA aims to answer the following research questions:

- How has COVID-19 impacted women, girls, men, boys across diverse groups and key vulnerable and marginalized groups' ability to meet their basic needs and entitlements?

- What achievements made on gender equality and the empowerment of women, girls and LGBTQ+ populations are now at risk of being undone by COVID-19?

- What new or heightened protection and safety risks are arising from COVID-19?

- How can women, girls, men and boys across diverse groups and key vulnerable and marginalized groups participate and lead in the COVID-19 response?

The RGA used a mixed methods approach, including secondary and primary data, and adapted the CARE Rapid Gender Analysis Toolkit. However, the analysis relies predominately on primary data with secondary data used to help understand the assessment results.

After the assessment tools were piloted and an enumerator training conducted, primary data collection conducted between 15 June and 9 July, an exercise led by CARE, Oxfam and UN Women.

Both quantitative and qualitative methods were used to collect primary data through closed-ended questionnaires and open-ended key informants' interviews (KIIs). For both methods, a combination of convenience and purposive sampling approach were used. Convenience sampling wad used to uphold COVID-19 containment measures and purposive sampling to ensure an even number of female and male respondents with representatives across all major age groups.

A total of 152 quantitative questionnaires were conducted with Rohingya respondents (50% women) in camps 1E, 1W, 3, 4, 4EXT, 5, 9, 10, 12, 13, 14, 17, 18, 20, 20EXT, and 20. Another 120 questionnaires (42% women) were conducted in the host communities of Palong Khali, Jalia Palong and Nhilla. For both Rohingya and host communities, most respondents were in Ukhiya (88%) compared to Teknaf (12%). The survey included multiple choice and closed-ended questions and was administered using a combination of face-to-face interviews and remote interviews over the phone. The results were recorded using mobile data collections tools surveys, such as survey CTO and Kobo Toolbox.

For the qualitative component, a total of 66 key informant interviews (27 Rohingya, 39 host community) were conducted by programme staff with 22 community members, 17

frontline workers, leaders and members of self-organized groups and 17 community-based groups (CBOs) and 10 local authorities. The local authorities interviewed included police (Assistant Superintendent, Sub-Inspector, and male and female constables), Camp in Charge and Assistant Camp in Charge, elected women leaders, majhis (male community leaders), representatives from the Ministry of Women and Children Affairs, and local government representatives from the host community. The key informants included women, men and transgender persons, female sex workers, elderly persons, persons with disabilities, youth and adolescents. The majority of the key informant interviews were conducted face-to-face, while a minority were also administered remotely via platforms such as WhatsApp and Skype. The interviews were predominately conducted in Bangla or Chittagonian and subsequently the interview notes were translated into English for analysis.

Secondary data was used to develop a pre-COVID-19 baseline against which to assess the changes and impact of the outbreak. The secondary data review used studies and assessments conducted prior to COVID-19 or at the onset of the pandemic, before cases had been confirmed in the camps.

Primary data analysis support was provided by ACAPS/NPM Analysis Hub. A dashboard was created to facilitate joint analysis between all participating agencies, and the results from the key informant were collated, and a preliminary analysis was conducted to support the report writing process that was led by the Gender Hub.

1.4   Limitations

The RGA is not representative of all diverse groups within the Rohingya and host communities, and some of the findings and conclusions may not be applicable to all camps as they are not all represented in the research. Additionally, children themselves were not directly interviewed and the findings related to them comes from conversations with parents/caregivers and adolescent youth. However, the RGA provides qualitative trends for programming considerations. All efforts were made to ensure as much representation as possible within the survey respondents and key informants and to ensure that key vulnerable groups were included. Given the restrictions in place due to COVID-19, face-to-face data collection was sometimes avoided, and quantitative surveys delivered over the phone were prioritized. Standard face-to-face consultations through KIIs were not always possible due to the COVID-19 transmission risk, so qualitative research was also conducted through phone conversations with key informants. Additionally, the information is from interviews that took place in May and June and some of the issues may already have been proactively addressed by sectors and working groups.

As men generally have more access and control over technology, particularly men from higher income groups, it is likely that this factor created a bias in the survey answers. There is also a potential bias due to enumerators being from various UN/NGOs – CARE, OXFAM and UN Women - rather than from independent researchers. Moreover, some respondents were also beneficiaries of these organizations.

1.5 Ethical and Safeguarding Considerations

COVID-19: Face-to-face data collection was carried out on a limited basis when phone-based data collection was not possible. All efforts were made to protect both respondents and enumerators from exposure to the virus. Enumerators received training on how to protect themselves and the respondents and were provided with masks and hand sanitizer.

Confidentiality and data protection: All quantitative surveys were confidential, with no personal or identifiable data collected. For the qualitative KIIs, names and other personal data were only collected with informed consent from the informant. It was emphasized that no identifying information would be shared externally hence this information has been omitted from this report.

Informed and ongoing consent: All surveys and KIIs were conducted on a fully voluntary basis and with informed consent. Informants and respondents were able to stop the survey or interview at any point.

Protection: All enumerators were trained on safe and survivor-centred handling of GBV, sexual exploitation and abuse disclosure.

Hassan (name changed to protect identity) is walking in the camp during COVID-19 pandemic.
Photo credit: Asafuzzaman Captain.

2 COVID-19 IMPACTS ON WOMEN, GIRLS, MEN AND BOYS ACROSS DIVERSITIES, AND KEY VULNERABLE AND MARGINALIZED GROUPS IN COX'S BAZAR

2.1. COVID-19 Driven Context Changes and Prevention

Rohingya refugees and host communities expressed concern about several significant changes to their lives and to services they could no longer access. This ranged from protection services - specifically support for GBV survivors, menstrual hygiene management (MHM) services, shelter, non-COVID-19-related health services, including for pregnant women, and education.

Most KIIs reported that unemployment and difficulties in accessing livelihoods opportunities were increasing as many humanitarian actors were unable to continue operating and providing jobs to the host community or stipends to Rohingya volunteers.

> **Things were normal before. People were not tense. Now people are worried about being affected by COVID-19. We used to meet friends and chat; we cannot do that now. People had jobs before, now they don't. People are mentally frustrated now, families used to be financially well off, but now everything has closed, and people are feeling the fallout from the financial crisis. Things were not like this before. Transport was available, but now if you have an emergency it's hard to get any transportation. People were not aware before, but now people of all ages and gender are wearing masks and washing their hands as soon as they come home. Women who wear hijab, do not need to wear a mask.**

(Male, 20, Host Community, CPJ Volunteer)

> **"** Many issues have increased. For example, before husbands could earn money to buy enough food for the family to eat properly. Now they can't so conflicts or quarrelling between husbands and wives has increased. Before NGOs used to give awareness-raising sessions and give advice to women on how to stay safe, now they don't and as a result some women have forgotten the advice, so their safety and security practices have decreased. There are other problems too. Before NGOs used to come to empty the toilet pits, now they don't, and the toilets are full of waste. Our children's education is at risk. Women have lots of problems at home and support for women's protection has decreased. Distribution of items like kits has decreased. As a result, women are getting sick and they don't go to the hospital because they're afraid. **"**

(Female, 18, Rohingya, CPJ Volunteer)

More information on these issues will be provided in the following sections, but the graphs below in figures 1 and 2 provide an overview of the main impacts of the Covid-19 containment measures on people's lives.

Figure 1. How do the lockdown and other imposed restrictions affect your life?
Host Community

Legend: Women, Men

	Women	Men
We cannot access food assistance	13%	11%
We cannot attend important social gatherings	14%	47%
We cannot access medical services	17%	14%
There are increased tensions in my household	17%	37%
We cannot go to other camps to visit our relatives	24%	18%
We cannot access other essential services	29%	14%
We have lost our income-generating activities	34%	43%
Our income-generating activities have been limited	36%	39%
We cannot access markets to buy food and essential items	38%	49%
Children don't go to school anymore	83%	89%

Figure 2. How do the lockdown and other imposed restrictions affect your life?
Rohingya Community
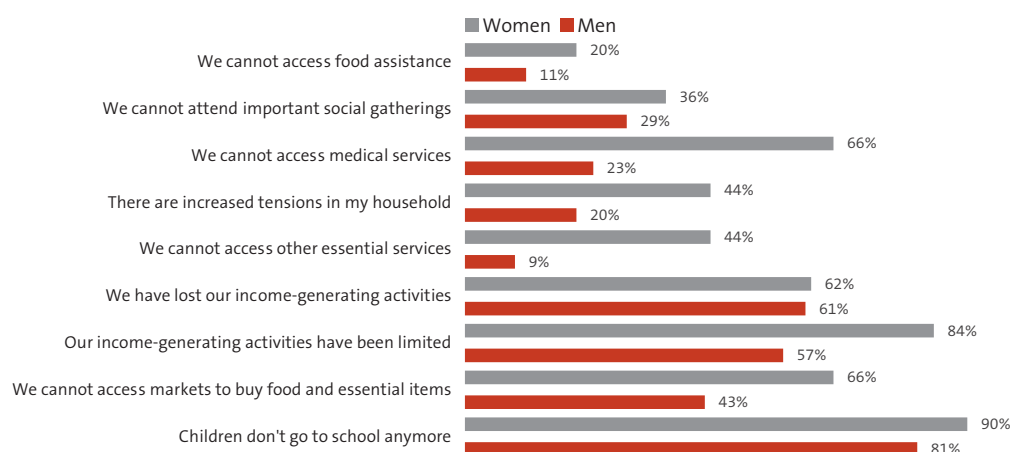
The results of the survey also indicate that, in general, prevention measures have been understood and most people attempt to follow them. Most survey respondents reported trying to practice physical distancing. However, it is clear from further KIIs that physical distancing and other measures have been extremely challenging to implement given the circumstances.

Congested conditions in the camps and limited facilities make it difficult to practice prevention measures, issues that several key informants noted, including Rohingya women leaders and frontline workers. Respondents from Rohingya communities were more likely to mention the size of their home as a reason to not observe physical distancing than those from host communities (74% vs 65%), while a few others did not believe it was important to do so outside the house (7% women and 26% men). This is in line with gender norms and roles which keep women and girls at home. Many key informants reported increased knowledge about and use of personal COVID-19 prevention measures among themselves and their communities. Youth volunteers and leaders claimed that the improvements in personal hygiene and preventive measures were positive as they may also contribute to decrease non-COVID-19-related illnesses.

> Now people wear masks, they are more aware, washing their hands – all measures to stay safe and clean. Children used to defecate in the open, people lacked personal hygiene and used to get diarrhoea a lot. Now these practices have changed. They wash their hands, keep their surroundings clean and they wear a mask. These are positive changes. As a result, people are getting sick less often.

(Female, 24, Rohingya, CPJ Volunteer)

Crowded and inadequate WASH and health facilities were reported as barriers impeding the wider population from adhering to the public health messages being disseminated. Some key informants highlighted additional difficulties that persons with disabilities faced as equipment and facilities needed to maintain hygiene prevention measures are not available. Another challenge to maintaining the measures was the limited access to PPE and hygiene items (masks, gloves, soap, and hand sanitizer in particular).

For host communities, financial constraints are the main challenge to, and impact of, following preventive measures. Loss of income has left many poorer households and individuals unable to purchase the necessary equipment. Some KIIs reported problems with understanding the prevention measures and with maintaining them within the existing household conditions. Five female sex workers interviewed reported that the additional expenses necessary to protect themselves adds to the financial burden already experienced due to their decreased income. As the livelihood of sex workers collapsed due to COVID-19 and the resulting containment measures, the need to travel farther than usual beyond their home communities for sex activities increased their risk of infection.

> **As a coping strategy for survival, we are taking both safety and security measures. We are working with those who look healthy and we request they wear a mask. If the customer is unwilling to wear a mask, then we don't work with them.**
>
> (Female, 22, Host Community, Sex Worker)

Some key informants noted gendered differences in maintaining preventive measures. Women were reportedly more likely to change their behaviours and practices in accordance with the guidelines, such as staying home and maintaining hygiene standards. Gendered differences were explained by the fact that respecting preventive measures represented a far more significant change for men, who generally take on a larger role outside the house, both in terms of livelihoods and in social activities. There were also reports of misconceptions, such as women thinking they would not be infected because they stayed at home. Some children did not understand the instructions and some older people were fatalistic. A minority of key informants mentioned that they or others did not believe in COVID-19, or they believed that God would protect them, a view that was more prevalent among men.[10]

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10 Oxfam, *"Perception Tracker"*, July 2020.

> **People who are using masks think that they only need to wear masks if they are sick. Eighty percent of people don't have masks. If they get water, they don't get soap. If they get soap, they don't get water. Many don't know how to use hand sanitizer. Children don't understand how. Men go out. Older people think if God wants them, then they'll get affected by the disease, or else that they won't - they believe in fate. Women think that they won't be affected by the disease since they stay at home.**

(Female, 45, Host Community, CSO Leader)

> **People with disabilities are facing problems, for example if someone goes near them, they can't move quickly. They have to keep their door closed so that people don't visit them.**

(Female, 43, Rohingya, Frontline Worker)

According to the results of the survey, in host communities, women were more likely than men to mention being unable to attend social gatherings (36% compared to 29%). However, in the refugee community, men were more likely than women to mention being unable to attend social gatherings (47% compared to 14%), such as weddings and funerals. They cited these examples as one of the ways the containment measures and movement restriction measures have affected their lives (see figure 1). While few key informants reported such differences, it is nonetheless important to note this as it adds weight to the hypothesis of the first RGA that gender norms and roles assigned to men and boys may have exposed them differently to the risk of COVID-19. It also provides a possible explanation for the findings of the health sector, which showed higher levels of COVID-19 testing for men than women in host communities.[11]

The containment measures and movement restrictions have impeded overall access to services, although greater difficulties were reported for women, girls, persons with disabilities and transgender persons. Movement restrictions, safety risks, limited transportation and controlled mobility were cited as some of the barriers faced by women and girls to access services since the COVID-19 outbreak. Some key informants, including frontline workers and women leaders, also mentioned that priority for accessing services is accorded to men and boys, with one male frontline worker specifically mentioning that majhis, or Rohingya camp

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11 World Health Organization, *"Coronavirus disease (COVID-19) Situation Report: Cox's Bazar Level Update"*, July 2020.

leaders, discriminate against women and girls while giving priority to men. Some frontline workers mentioned reports of harassment of women and girls at distribution points.

Transgender persons mentioned the particular impediments they faced in accessing services during the pandemic. As transgender persons and other vulnerable women and girls are often served last, when resources are limited, they miss out. Before COVID-19, they reported needing to give tips to receive services; their loss of income means they no longer have this option. Another challenge reported by one transgender informant was the difficulty in manoeuvring gender-segregated lines at distribution points and facilities.

> **Transgender, older people with chronic diseases and people with disabilities are more vulnerable in this situation. Transgender people do not have easy access to services from any service centre. For example, they only receive services after the centre has finished providing services to all other clients.**

(Transgender, 21, Rohingya)

The Age and Disability Working Group reported similar findings for persons with disabilities, who often face lower social status and discrimination and are served last. Services for persons with disabilities, such as rehabilitation services and assistive device services, initially stopped. While these services have now resumed, they have been significantly reduced since COVID-19. According to Lighthouse[12] drop-in centres providing services for female sex workers in different locations have significantly limited their services since the COVID-19 containment measures were implemented. These were centres where female sex workers could come, rest, shower, cook food and eat, undergo STI testing, treatment and receive other sexual reproductive health services.

Information dissemination and awareness efforts by the government and humanitarian actors must be commended as many segments of the population have been reached. However, as mentioned in the ethical considerations section above, the phenomenon of potential bias should also be considered.

Some frontline workers interviewed reported feeling unsafe due to being unable to practice physical distancing and the belief that COVID-19 was widespread in the camps. Interviewees highlighted that the increase in prevention measures and containment rules also made it more challenging for them to do their jobs. One key informant said that although they felt as secure as they could working in the camps, they feared infecting their own families. These findings were consistent across men and women informants.

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12 Light House is a non-profit voluntary development organization working for the development of rural and urban asset less poor, marginalized and high-risk populations.

> **66** I feel unsafe, especially when providing services and travelling. The office provided me with a mask and hand sanitizer, but the sanitizer is already finished, and the mask is being reused after being washed again and again. **99**

(Male, 25, Host Community, Frontline Worker)

2.2 Gender Norms and Roles

The burden of unpaid care work has increased due to COVID-19 prevention measures and it remains almost exclusively the responsibility of women and girls. Most key informants, from police officers to frontline workers and women leaders, described an increase in household work as preventive measures increased the importance of hygiene and cleanliness, and the containment measures and movement restrictions meant all family members spend more time at home. This includes cleaning, cooking, collecting water and taking care of the children, the elderly or ill relatives. Men and women agreed that women and girls are primarily responsible for this work. This gender norm and role of caring for the sick places women and girls means they are being exposed to the risks of COVID-19 differently.

> **66** Women are always expected to do more household chores than a male family member. To ensure cleanliness, washing has increased since the pandemic, so it's obvious that the workload has doubled. Men lost their income sources due to the virus. They are spending more time in the house, but they hardly participate in the household chores as the social practice is that men only work outside the home and are solely responsible for earning. **99**

(Female, Host Community, Police Officer)

Some interviews with Rohingya female informants suggested that Rohingya men and boys started helping more with household chores since the onset of COVID-19. This is in line with the findings of the last RGA. However, responsibility for most unpaid care work still falls on women. Most host community informants, whether men or women, reported that despite the increased workload, men did not take on household chores. Informants explained that this was due to traditional gender roles, where women are responsible for unpaid household work and men only engage in paid work outside the home.

As livelihood options have been greatly reduced, men struggle to fulfil their traditional role as the primary breadwinner which leads to increased stress and tension in the home. The effect of the containment measures on income-generating activities was one of the most reported impacts felt by men in both Rohingya and host communities. When discussing needs, women in host communities also reported that the priority for men and boys was

livelihoods. This was also the case for Rohingya men and boys, second to health care. Interviews with key informants revealed that men's inability to fulfil what society deems to be their primary role has resulted in increased stress and tension. The consequences of this are further described under the sections on mental health and intimate partner violence.

> **Men have suffered a lot from COVID-19. Many have had their salaries reduced and some have lost their jobs. So, the situation is a new experience for society, and people, especially men, were not prepared for the crisis.**

(Male, Host Community, Police officer)

> **In this crisis, people are taking more care of children and the elderly. But, women's duties (work) have increased, children are spending the time when they should be at school with their mothers. In staying at home men are realizing how great a work burden falls on women's shoulders. Although violence has increased, now men are helping women, including in cleaning. Men are going out to get the rations mostly. Women are also going because the rules are so strict now that only the owner of the card can get the ration. Men, women - both are going now.**

(Female, 45, Host Community, CSO Leader)

2.3   Decision-making Power and Agency

Decision-making power does not appear to have changed during the pandemic, with Rohingya women and girls still failing to have a significant decision-making role. More than half of Rohingya women surveyed (55%) reported needing permission to make purchases related to COVID-19 prevention (e.g. soap, masks). This changes with age: women aged 18-35 were more likely to report needing permission (63%) compared to women aged 36-60 (37%). When it comes to health decisions, women had even less power: 61% of Rohingya women reported needing permission to access health services, including isolation and treatment centres, if they had COVID-like symptoms. This also correlates with age: 64% of women aged 18-35 need permission to access health care compared to 53% of women aged 36-60. This is also correlated with marital status, 62% of married women (in monogamous or polygamous marriages) need permission to seek health care compared to 55% of unmarried women. Unsurprisingly, in female-headed households, women have more decision-making power: 55% of women in female-headed households do not need permission to make purchases and 47% do not need permission to access health services.

Almost half of host community women (46%) reported being able to make their own health decisions, and 70% make their own purchasing decisions. This also changes with age: women aged 18-35 were more likely to report needing permission (33%) compared to women aged 36-60 (25%). As with Rohingya communities, this was correlated with marital status: 62% of married women (in monogamous or polygamous marriages) need permission to seek health care compared to 20% of unmarried women. Women in female-headed households also have more decision-making power: 86% of women in female headed households do not need permission to make purchases and 71% do not need permission to seek health services.

Men are still the primary decision-makers in the household, which can limit the ability of women and girls to make critical lifesaving choices around COVID-19. Most women reporting being unable to make their own health or purchasing decisions said they need their husbands' approval. For Rohingya women, permission to seek health care was gained from husbands (49%), mothers (16%), and fathers (13%). For women from the host community, permission to seek health care came from husbands (50%), mothers (4%), and fathers (2%). It is unclear whether mothers need to consult their husbands about their daughters' needs. Key informants noted that men continue to make decisions on behalf of their household, including on expenditure, health care, family planning and early, forced and child marriage.

> **Generally, men make decisions regarding health care. Some women are using family planning methods, but many women do not want to take it on their own due to religious tenets. Then they advise others not to take family planning. Women say they will commit a sin if they go to the centres to adopt family planning methods. Health-care services have decreased in this crisis. Pregnancy rates have increased, and some women don't get proper care, others don't want to get care during pregnancy. The health care system has broken down. Before women could keep themselves a bit safe, but now they are not accessing health services.**

(Female, 45, CSO Leader, Host Community)

> **COVID-19 has brought change – now women fear getting pregnant due to problems arising from COVID-19. One particular difficulty facing Rohingya women is that the respective staff of the health centres are asking very personal questions while providing services, which upsets the Rohingya women. This discourages them from applying for family planning services from the service provider.**

(Female, 30, Rohingya, Women Leader)

The containment measures and movement restrictions have impacted the ability of women and girls to negotiate the rigid set of norms that govern their lives. In an interview, a Bangladeshi female ward member of Union Parishad explained that with men now at home all the time, women's movement and agency were being increasingly policed. Prior to the pandemic, women could visit different places while their husbands were not home. Some key informants, including male police officers, disclosed that this situation impacts women's ability to seek support, including from the police, NGOs or other assisting agencies.

> **Women are more stressed as they cannot complain and receive counselling from the police or other agencies due to the containment measures situation. Older people are also suffering from stress and anxiety as their family members have lost their sources of income and they feel helpless being unable to contribute to health expenses.**

(Male, Host Community, Police Officer)

This is worrying given that GBV, including intimate partner violence (IPV), is reported to have increased during the pandemic.[13] Some key respondents suggested that decision-making power is linked to income- generation, so when women earned money, they were more able to make decisions for themselves. This was also mentioned by a transgender respondent, who noted they could make personal decisions around health care and expenditure when earning their own income, although household decisions were still made by adult cisgender men. Both findings are anecdotal and warrant further investigation, but they shed light on the more nuanced impact of COVID-19 on gender equality and the agency of women and girls.

2.4 Achievements at Risk of Being Undone

Since 25 March, in an attempt to reduce the risk of COVID-19 transmission in the camps, the Refugee Relief and Repatriation Commissioner, on behalf of the Government of Bangladesh, published guidelines to significantly reduce the humanitarian footprint in the camps. [14] As a result, many services for women have become harder to access or have shut down, including services for MHM, sexual reproductive health, or protection, as well as women and girl friendly spaces. Gender transformative programming, including leadership and skills building for women and strategies to end harmful practices and abuse, such as early, forced and child marriage and GBV, rely heavily on activities that can no longer take place, such as livelihoods and education opportunities for women and girls, broader community

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13 ISCG Gender Hub, CARE Bangladesh, Oxfam, UN Women, *"COVID-19 Outbreak Rapid Gender Analysis"*, May 2020.

14 Refugee Relief and Repatriation Commissioner, *"Letter No-749: Restricted Programme in Light of Covid-19"*, 8 April 2020.

engagement, behavioural change, awareness-raising, advocacy and engaging men and boys in accountable practices.

Services provided to female sex workers have stopped at a time when this group faces increased risk in terms of protection and health, in addition to exposure to COVID-19. Some KIIs highlighted that Rohingya men and boys have been taking on more of the unpaid care work than before, suggesting that gender programming in the camps may have had a positive impact. With these programming activities no longer deemed essential, this progress may be reversed.

The marriage approval process led by the CiCs was also reported as having a positive impact in addressing early, forced and child marriage. However, with COVID-19 restrictions and a reduced presence of actors in the camps, this has stopped, potentially contributing to the reported increase in early, forced and child marriage among the Rohingya, a practice that has been clearly reported as a coping mechanism by other studies.[15]

Rohingya woman engaged in mask production in UN Women/BRAC Multi-purpose women centre in camp 3. Photo Credit: Marie Sophie Pettersson.

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15   UN Women. *COVID-19 Bangladesh Rapid Gender Analysis,* 2020.

3 KEY FINDINGS AND RECOMMENDATIONS BY SECTORS AND WORKING GROUPS

The following figures highlight the priority sectors and working group identified by women and men in Rohingya and host communities based on their needs and concerns.

3.1 Communication with Communities

Findings	Recommendations
• COVID-19 prevention measures were mostly known and understood, but following them was challenging for women, girls, men and boys among both the Rohingya and the host communities due to living conditions and financial challenges. Gendered differences in maintaining preventive measures were identified, where women are more likely to change their behaviours and practices, in accordance with the guidelines, gender norms and roles assigned to women and girls, men and boys puts them at varying degrees of exposure to risks of COVID-19. • Rohingya refugees both prefer and rely on information that is provided by people. Women prefer door-to-door visits, while men prefer loudspeaker announcements, informal discussions and public meetings. In the host communities, technology is the most preferred and trusted way to receive information, with both women and men preferring to receive information from television channels. • Men and women from the host community have less scope to participate in surveys conducted by the response, especially women, as they are less consulted and less likely to give feedback or make complaints.	**Urgent Priorities:** 1. Communication on the risks of COVID-19 disseminated across all mechanisms for host communities needs to include information on available support from the government and humanitarian organizations, as well as how to access it. 2. Communication must be immediately improved through specific consultation to create two-way interaction thereby being able to listen to concerns and myths/misinformation in both the Rohingya and host communities and to be able to respond with localized, culturally and religiously specific accurate messaging. 3. Prioritize work with religious leaders through regular dialogue to engage in two-way risk communication around the COVID-19 and the importance of maintaining preventive measures and dispelling misperceptions, specifically those that affect women and girls. 4. Strengthen the system for tracking and responding to misperceptions affecting women and girls by developing targeted messages that female volunteers can use when engaging women and girls and by incorporating these into messaging for men and boys. Monitor the effectiveness of targeted messaging. 5. Immediately strengthen communication mechanisms by incorporating specific feedback and the report's findings (e.g. more use of door- to-door visits for women). **Continuing Priorities** 6. Ensure all ongoing communication on risk and community engagement on COVID-19 effectively targets women and girls, persons with disabilities, the elderly, female sex workers and transgender persons, including through collaboration with female community leaders and civil society organizations representing these groups. Adapt messaging to make sure the information and method of dissemination is relevant and appropriate to their needs, addresses their difficulties and responds to their concerns. 7. Ensure that complaint and feedback mechanisms are accessible to everyone in terms of timing, language, location and method of dissemination (such as audio or visual in relation to special needs), especially for women, girls, transgender persons and persons with disabilities. Service providers must give feedback in a timely manner in a way that is safe and based the recipient's gender-based preference.

Access to information

Rohingya communities prefer and rely on information provided by people. Door-to-door visits, loudspeaker announcements, informal discussions, public meetings, and social media were all considered trustworthy means of receiving information.

Rohingya women preferred door-to-door visits. Some female key informants noted that women also receive information from male relatives. Men preferred loudspeaker announcements which are easier for them to hear as they have more access to public spaces.

Technology is the preferred and most trusted way to receive information for host communities. Both men and women in host communities overwhelmingly trust news received via television. Women also preferred social media and loudspeaker announcements, while men preferred radio and loudspeaker announcements. The fact that 68% of women in host communities prefer social media is significant as the risk of fake news does exist.

Who people trust to receive information and updates from depends on gender and age. Younger Rohingya women (18-35 years) largely trust volunteers and community leaders, while older women in the 36-60-year category trust community leaders and service providers. With most community leaders, such as religious leaders or majhis, being men, this creates a barrier for women and girls who may feel less comfortable raising their personal issues with them. This was supported by the key informants' reports that women-friendly spaces were a trusted means of getting information for women. With these no longer operating in the same way since COVID-19 the outbreak, women have lost a preferred source of information. Rohingya men predominantly trust community leaders, followed by camp authorities, such as CiCs and police. Host community women trust the local authorities to receive information, although younger women trust volunteers more compared to older women, who favour community leaders. The local authorities are also the most trusted source of information for host community men of all ages, although younger men also trust relatives and older men trust both their relatives and religious leaders.

Religion appears to be an important factor in whether people believe the messages they receive concerning COVID-19. Some informants from both communities made references to God and the importance of prayer, and some believed the virus was punishment from God. Many informants mentioned prayer and other religious rituals as a means to protect themselves from infection. It was also reported that religious people, especially older people, believed God would protect them from the virus, and therefore they felt no need to take the necessary preventive steps to avoid infections. Some key informants recommended that religious leaders take on a bigger role around awareness-raising on COVID-19 and on preventive measures as their status meant they could reach the more religious segment of the population.

Consultations

Rohingya men reported that humanitarian actors had consulted them to understand their needs, concerns and perceptions on the COVID-19. Over 80% of men reported had been consulted at least once by humanitarian actors on COVID-19, among whom 72% were consulted multiple times. Younger men (aged 18-35) were slightly more likely to be consulted (94%) compared to those aged 36-60 (89%). According to secondary sources, older people are less likely to be consulted about their needs[16].

Seventy percent of Rohingya women reported that humanitarian actors had consulted them on their needs and concerns around COVID-19 at least once, of whom 59% were consulted multiple times. However, age was a factor: women aged 18-35 were more likely to be consulted at least once (73%) compared to women aged 36-60 (58%). In the previous RGA, concerns were raised about the low levels of consultations and engagement by humanitarian actors with women and girls. This may indicate that efforts to ensure that the needs of women and girls are understood have to some degree been successful.

Host communities reported that they were much less consulted in comparison, especially women. Two-thirds of men in host communities reported that humanitarian actors had never consulted them on the COVID-19. The corresponding figure for women was 82%. Both younger men and women were slightly more likely to be consulted. Considering the different experiences and needs of host community women and men, it is essential that community engagement is prioritized and more consultations held with the host communities to tailor a response to their needs. Not surprisingly, when asked in what manner they wanted to be more involved in the COVID-19 response, 72% of host community women said they wanted to be consulted about their needs, while only 39% of men reported the same.

> **Women prefer to receive information from women, and men prefer receiving information from men... Women consider any information to be very important when they obtain it from women friendly spaces. There are network/ Internet problems in the camps. If you want to give any information, you have to convey it through people. Even if we want to, we are unable to give information to everyone effectively.**

(Female, 45, Host Community, CSO Leader)

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16 BBC Media Action, Internews and Translators without Borders, *"Communication to Counter the COVID-19 'Infodemic'"*, March 2020.

Feedback and Complaints

Almost all Rohingya women (91%) said they would report a complaint to community leaders, such as majhis, while half would also approach humanitarian actors. While the preference for majhis does not change with age, women in the 36-60 age category are more inclined to seek support from CiCs (52%) instead of humanitarian actors (37%). The importance placed on majhis within the Rohingya community points to the need to build their capacity to address the needs of women and girls and to provide women-friendly support. Women (19%) are twice as unlikely to use complaint boxes compared to men (36%), although this is not the preferred way to report complaints. Complaint boxes are therefore not a highly effective way to collect complaints and feedback from women, and they should only be used in conjunction with other feedback mechanisms, especially considering the literacy levels of women and girls.

A total of 89% of men would report a complaint to a majhi, but unlike women, they would approach CiCs (59%) over humanitarian actors (49%). This is consistent across ages. The importance placed on majhis highlights the need to work with these actors to build their capacity in order to provide effective support to the Rohingya population.

Rohingya women are less likely than men to make complaints and when they do, these complaints are less likely to be resolved. When asked whether they had reported a complaint or an issue in the last 30 days, only 17% of women answered in the affirmative compared to 41% of men. Of those who made a complaint, 77% of women and 87% of men said they had been contacted to provide more information. However, when asked if the issue had been resolved after making the complaint, only 31% of women said, "yes" compared to 61% of men. When complaints are resolved, both men and women reported being satisfied with the outcome.

Host community women and men report complaints almost exclusively to the local authorities and administration. It is the first choice for host community women (80%) and men (86%), with a minority (10% of women and 17% of men) who would opt to complain to humanitarian actors.

Host community women and men are much less likely to report a complaint or issue, especially women. No host community women surveyed had reported a complaint in the last 30 days, and only 13% of men had done so. Those that did were contacted two-thirds of the time to obtain more information, and only half (56%) of these complaints were resolved. When they are resolved, twenty percent of the time the complainants are not satisfied with the outcome.

Participation and decision-making

In Rohingya communities, 62% of women want to be consulted about their needs and involved in deciding response activities. Half also want to actively participate in response activities. For host community women, 72% want to be consulted about their needs, while a little over half want to be involved in deciding and participating in response. Efforts to include women and adolescent girls in the response needs are to be revived, starting with

consultations about their needs and concerns, but also assigning them a more active role as decision-makers and participants.

During KIIs, transgender persons and women reported being unable to participate in preparedness and response mechanisms. Interviews with transgender persons showed that discrimination against them left them unable to participate in the response, which often resulted in their exclusion from aid. Rohingya women leaders and volunteers raised similar issues for women and girls, who find it difficult to participate in forums, meetings, or other decision-making spaces that are dominated by men. Key informants, including transgender persons, police officers and women leaders and volunteers, noted the need for humanitarian actors to ensure the engagement of underrepresented and marginalized groups by actively seeking out their opinions, by engaging them as volunteers and by working more closely with civil society organizations that represent their interests.

Rohingya men also want to be more involved in decision-making related to the response, although at lesser rate than women, and host community men even less so. Over half of Rohingya men want to be consulted about their needs, and around 40% want to be involved in deciding and participating in response activities. However, 25 percent were not interested in being involved. For host community men, the proportion of men not wanting to be involved increases to one third.

3.2   Education

Findings	Recommendations
• Lack of access to education for children is a concern for both the Rohingya and the host community. • The pre-existing gender bias for boys' education is likely to be exacerbated with new schooling arrangements.	**Urgent priorities** 1. Increase awareness sessions and guidance for parents/caregivers on ways to help children and adolescents of both sexes with home-based learning, prioritizing time for girls to learn and for preventing early, forced and child marriage, the negative psychosocial impacts of COVID-19 restrictions, the increased domestic responsibilities for girls and school dropouts. 2. Provide adequate learning resources and materials for home-based learning to ensure boy and girls and adolescents continue to access education.

The most significant impact of COVID-19 on children is that they can no longer attend school. This was reported by both women and men in both the Rohingya and host communities. For Rohingya refugees, 83% of women and 89% of men identified this as the main way containment measures and restrictions have affected the lives of their children, while 90% of women and 81% of men in host communities gave the same answer.

The majority of Rohingya children now study at home on their own, but lack of learning materials is a challenge.[17] Only half of respondents reported receiving information or resources from an education assistance entity or NGO on how to continue learning at home. Moreover, as women and girls are perceived to be primarily responsible for care work (described in the gender norms and roles section later), girls are likely to face more difficulty allocating time to home-schooling than boys. Even before COVID-19, only one third of Rohingya adolescent girls attended learning centres, compared to two-thirds of adolescent boys.[18] The lack of support for at-home learning will likely lead to many adolescent boys and girls dropping out, although the increase in unpaid care work and the low valued placed on girls' education will place adolescent girls in a worse situation.

Host community children also learn on their own now that schools have closed. Almost 90% of children learn on their own for an average of two hours a day, and approximately 50% of children have a family member help them, according to a Samaj Kalyan O Unnayan Shangstha (SKUS) survey in host communities.[19] Very few households (26%) received information and resources from the school or NGOs on continuing learning at home. The lack of learning materials was the main challenge raised by both women and men. Cox's Bazar has a high level of child labour, with 8% of households in host communities reporting at least one child working.[20] The lack of support for at-home learning, combined with the adverse impact of the containment measures on livelihoods and the increase in unpaid care work is likely to push adolescent boys and girls to drop out permanently to help their families.

Access to education was previously a strategy to delay marriage. The closure of schools is likely connected to the increase in early, forced and child marriages. Discussions with Rohingya youth leaders and volunteers revealed that the loss of educational opportunities for both adolescent girls and boys was one of the reasons for the perceived increase in early, forced and child marriage. This issue was also raised as a concern in the national Rapid Gender Analysis and is further discussed in the child protection section.[21]

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17   Samaj Kalyan O Unnayan Shangstha. *"Coronavirus (COVID-19) Rapid Survey of Rohingya Community"*, July 2020.

18   Inter-Sector Coordination Group, *"2019 Joint Response Plan for Rohingya Humanitarian Crisis (January-December)"*.

19   Samaj Kalyan O Unnayan Shangstha. *"Coronavirus (COVID-19) Emergency Response Messaging Rapid Host Community Survey - Final Report"*, July 2020

20   Gender and Adolescence Global Evidence, Innovations for Poverty Action, Yale, *"The Lives They Lead: Exploring the Capabilities of Bangladeshi and Rohingya Adolescents in Cox's Bazar, Bangladesh"*, December 2019.

21   Inter-Sector Coordination Group Gender Hub, CARE Bangladesh, Oxfam, UN Women, *"COVID-19 Outbreak Rapid Gender Analysis"*, May 2020.

3.3 Food Security

Findings	Recommendations
• Access to food assistance has been insufficient for Rohingya refugees, particularly single mothers, households headed by persons with disabilities, pregnant and lactating women, the elderly and children. Respondents additionally reported a deterioration in food quality. Host communities also face overwhelming difficulties accessing sufficient food, with women sharing concerns about changes in prices at the market, access to distributions and the lack of income. • The economic consequences of the pandemic and its associated preventive measures have had one of the most significant impacts on women, girls, men and boys in both communities, affecting their livelihoods, which in turn limits their ability to seek services or meet their basic needs, and they have increased the risks concerning protection. Women, who are mostly engaged in the informal economy, and vulnerable groups dependent on daily work, such as persons with disabilities, transgender persons and sex workers, have been hardest hit.	**Urgent Priorities** 1. Immediately improve food distribution mechanisms, as well as community feedback and reporting mechanisms related to this, to reach the most vulnerable, including persons with disabilities, the elderly, single mothers, and transgender persons by ensuring distribution modalities are safe, accessible, and non-discriminatory. 2. Income generating/self-reliance activities need to increase and engage the most vulnerable in camps and host communities, including women, especially single mothers and female heads of household, female sex workers, transgender persons and families with dependent children/persons with disabilities. Examples include homestead gardening that mitigate environmental degradation through soil conservation and the production of masks and reusable pads. **Continuing Priorities** 3. Increase information dissemination and community engagement on government safety nets to women of host communities, particularly vulnerable groups, such as persons with disabilities, transgender persons and female sex workers.

Rohingya women and men both overwhelmingly reported an inability to access enough food for themselves and their families due to the disruptions caused by COVID-19. Three-quarters of women (76%) and men (74%) reported changes in distribution networks and market prices since the COVID-19 outbreak. Women reported an increase in market prices, hindered access to food due to the COVID-19 containment measures and changes in distribution modalities, and lack of income or savings to purchase additional items as their main challenges. Men referred to the same challenges, albeit without reference to market prices and with more focus on a lack of income or savings.

Based on the interviews conducted among the Rohingya, the quality and quantity of food has worsened. Provisions for new distribution modalities were introduced for food assistance.[22] Beneficiaries are now provided with food assistance once a month through

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22 World Food Programme Bangladesh, *"Situation Report #35, Rohingya Refugee Response"*, February 2020.

general e-voucher food distributions to limit people-to-people contact and to ensure adequate social distancing. Daily door-to-door beneficiary mobilization has been suspended with beneficiaries receiving a permanent monthly distribution token instead. Only one person per household can enter the World Food Programme (WFP) distribution points, top-up points for the vouchers and access help desks.[23]

Several KIIs with Rohingya informants and frontline workers revealed that these changes in the distribution modality resulted in lower quality food and less diversity. One KII revealed that the new distribution modalities no longer allowed refugees to check the food they received for potential quality issues. Reports of delays in distribution and long periods between distributions were also raised. This led many to worry that vulnerable groups, such as children and pregnant and lactating women, were not receiving enough nutritious food, leading to potential health problems, including weaker immune systems.

> **Before COVID 19 we could take food from the distribution centres after checking it very carefully, but now in the COVID-19 situation we cannot check properly. Much of the food becomes rotten after two days and our health suffers. The schedules for food distribution are now quite long, so we are facing a food crisis. The amount of rations distributed is also inadequate now during the COVID-19.**
>
> (Female, 17, Rohingya, Youth leader)

Women reported having to confront barriers in accessing distribution points and additional food. Almost half of refugees (46% of women and 42% of men) reported changes in who collects food and non-food items since the COVID-19 outbreak. Men are now collecting food instead of women. Some key respondents reported harassment of women and girls at distribution points and the prioritization of men and boys over women and girls. Changes also included no longer being able to go in groups and no longer letting children go. Around 7% of those who reported changes noted that before non-family members, including porters, used to collect food and non-food items, but now family members had to go.

This may have implications for households headed by persons with disabilities, pregnant women, the elderly and children. One KII noted that it had become harder for single mothers, as they received less support than before and needed to leave their children alone when they went to the distribution centres. This finding indicates that the absence of assistive support for distributions that was provided pre-COVID-19 has exacerbated problems for some vulnerable groups.

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23 Ibid.

> **Women are facing a lot of problems, especially women who don't have husbands. They have to leave their children at home and come to the distribution centre. Before there were people to help them. Now there's no one to a them. Everyone's helping themselves. Women have to stay in the queue for a long time, sometimes it takes a whole day. It's really difficult for women.**

(Female, 26, Rohingya, Frontline worker)

Host communities overwhelmingly reported difficulties accessing sufficient food, although it was a greater concern for women. Seventy-seven percent of men and 94% of women in host communities reported being affected by changes in market prices and said that the food distribution was available to a small number of vulnerable people. As the host community population are not reliant on food assistance and therefore do not have continued support, they are more susceptible to difficulties arising from loss of income and increased market prices. Almost all women attributed the increased difficulty in accessing sufficient food to the increase in market prices (90%), sometimes coupled with a lack of income or savings to purchase items (64%). Women also noted the lower quality, quantity or variety of goods in markets. For men, lack of income or savings to purchase items was the main challenge (73%), followed by increased prices (56%). Market access is the third highest impacted service for women, along with medical services. Poorer households struggle to afford food, and food was reported as a priority need for both women and men in host communities (see figures 4 and 6 above). Very few changes were observed in terms of who goes to get food, but when changes were observed, it was principally men that went instead of women, and they go alone instead of in groups. This illustrates in concrete terms the hypothesis that gender roles and norms influence the different ways that men and boys and women and girls are exposed to the virus.

> **For example, when they need 15 kg of rice every 15 days and used to get a ration every 15 days, now they are getting 12 kg rice per month - so what are they to do during the remaining 14/15 days? Their needs are not being met. The health-care system has broken down, but food is the main issue now, the top priority, more than clothes. If people don't get fed properly and on time, they will be in a lot of trouble. Isolation healthcare centres are being built in front of Kutupalong and Balukhali camps, but people who live far are not receiving services. They are not thinking how the people who live farther away could come to the centres.**

(Female, 45, Host Community, CSO Leader)

3.3.1 Livelihoods and Income

One of the most significant changes reported since the COVID-19 outbreak has been the loss of income and livelihood opportunities. Over one third of refugees reported that containment measures have partially or completely stopped their livelihoods activities. This was slightly higher among men than women: 34% of Rohingya women and 43% of Rohingya men reported that they or their family had completely lost their income due to containment measures, while 36% and 39% of Rohingya women and men respectively reported that containment measures limited their income (see figure 1 on page 12). Reports of volunteers losing their stipends due to projects closing and organizations no longer operating in the camps due to the containment measures were also mentioned.

In host communities, the impact seems to be even higher, with over two-thirds of respondents reporting that containment measures have limited or stopped their income-generating activities, although this time women were more likely to report this. A total of 84% and 57% of host community women and men respectively reported containment measures had limited their livelihoods activities, and 62% and 61% of host community women and men reported having completely lost their income.

As Cox's Bazar is one of the poorest districts of Bangladesh and there are over 860,000 Rohingya refugees who are almost entirely dependent on aid, any crisis that hinders livelihoods will have significant consequences in regard to basic needs, such as food security, adequate nutrition, health and education. According to the Cox's Bazar District Administration, over 700,000 people are assumed to have lost their jobs due to the restrictions.[24] Livelihoods were reported to be a priority need by 62% and 5% of Rohingya men and women respectively, and by 86% and 90% of host community men and women. As host communities do not receive blanket food assistance, livelihood and work opportunities are the main way of meeting their daily needs.

In Bangladesh, 92% of women work in the informal sector and have little access to formal safety nets or support from the public or private sector.[25] Women are also less likely to know about government safety nets or claim support and services from the government than men in host communities.[26]

Groups that already faced stigma and discrimination and rely on daily work to meet their basic needs are especially vulnerable. Female sex workers reported a significant decrease in income due to movement restrictions, which hinder them from meeting their clients and has reduced the total number of potential clients. Moreover, many potential clients have also lost their source of income and can no longer pay for their services; the five sex workers interviewed all mentioned being forced to accept lower prices for the same services.

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24 Inter-Sector Coordination Group, "*Covid-19 Response Plan: Addendum to the Joint Response Plan 2020 - Rohingya Humanitarian Crisis (April - December 2020)*".

25 Inter-Sector Coordination Group Gender Hub, CARE Bangladesh, Oxfam, UN Women, "*COVID-19 Outbreak Rapid Gender Analysis*", May 2020.

26 Samaj Kalyan O Unnayan Shangstha. "*Coronavirus (COVID-19) Emergency Response Messaging Rapid Host Community Survey - Final Report*", July 2020.

> " Before the crisis, we had income. Lots of tourist came to Cox's Bazar, so we had lots of tourists as clients. And we could earn a fair price, sometimes more money. If we worked a whole night with a client, we earned BDT4,000- 5,000 per night. Even if we worked two to three hours, we got BDT 1,500 – 2,000. So that monthly we can earn BDT17,000 – 20,000. But due to the Corona virus, most areas are under containment measures, the tourists cannot come to Cox's Bazar, so we lost our market. As an alternative income source, we have chosen to work with local clients now like fishermen, businessmen, shopkeepers, drivers and boat drivers who have less money. After finishing work, some customers pay us properly, but others don't pay up. Also, all business stopped due to COVID-19 so businessmen were unable to operate their businesses and earn enough money. Hence they cannot afford to pay sex workers. "

(Female, 25, Host Community, Sex Worker)

While the government has distributed some food aid to brothel-based sex workers, this has been insufficient, with handouts to sex workers smaller than for other groups due to discrimination.[27] According to Lighthouse, these services have not yet reached female sex workers and many have become jobless and homeless due to COVID-19-related containment measures. Similarly, transgender persons who rely heavily on daily work, begging or sex work have also reported a decrease in income due to the containment measures and movement restrictions. Social stigma and discrimination have made it very difficult for them to access government relief, and many are dependent on their families to survive. Moreover, the Age and Disability Working Group reported that their self-help group members with disabilities from host communities, many of whom are casual workers, were also impacted by the containment measures and not always able to continue their livelihoods activities.

27 Inter-Sector Coordination Group Gender Hub, CARE Bangladesh, Oxfam, UN Women, "COVID-19 Outbreak Rapid Gender Analysis", May 2020.

> " People with disabilities used to get some money but that has stopped. They used to get food, rice, sugar, oil, dal and more, but they are not getting those items now. The wheelchairs they have are damaged and they can't inform the NGO so as to get repairs or a new one. Blind and disabled people used to receive support, but now such support has stopped. "

(Female, Rohingya, Frontline Worker)

> " We have been affected badly because of Covid-19. My family are daily labourers. I saved some money but now I've spent it all. So I'm broke. No work. I haven't been able to work for three years because of my illness. I have two sons who used to be daily labourers, but they are also jobless now. "

(Male, 52, Host Community, PWD)

3.4 Health

| Findings	Recommendations
• Increased difficulties accessing health services have been reported during the pandemic, with increased feelings of distrust, dissatisfaction and misinformation. • Women, children, transgender persons and persons with disabilities all face more barriers in accessing health services. • Access to crucial services such as sexual, reproductive and maternal health services have been reduced. • There is an increase in mental health issues, in feelings of insecurity and stress across the board, in particular among men and boys. • Previous work on protecting and empowering women and girls has been disrupted due to the containment measures, making it harder to access services like menstrual hygiene management (MHM), sexual reproductive health, protection, women and girl friendly spaces, leadership and skill-building for women, access to justice for GBV survivors, education and livelihoods. This is because such services and activities were deemed non-essential.	**Urgent Priorities** 1. Increase the provision of mental health support to everyone. 2. Increase the number of door-to-door community health worker volunteers ensuring a gender balance and representation across diverse communities in raising awareness. 3. Ensure all facilities for testing, treatment and isolation facilities for COVID-19 are fully gender segregated 4. Increase targeted efforts at reaching out to women, in line with recommendations for CwC, to promote their health seeking behaviour. 5. Consider engaging unlicensed/traditional doctors, whose shelters have become popular treatment sites, to reach the wider population with relevant COVID-19 messaging, including on gendered aspects. 6. Take immediate measures to address fears and misperceptions regarding isolation facilities, disease fatality and treatment options, with special consideration to women and girls and to the social and religious barriers in accessing such facilities. 7. Advocate to maintain all critical services and supplies for all forms of sexual and reproductive health care (including long-acting reversable contraceptives) and provide information to women and adolescent girls on how to continue accessing these. **Continuing Priorities** 1. Ensure that all health actors are provided with gender sensitive and protection training with the intent to improve trust with community members. 2. Strengthen collaboration between health sector, CwC and Gender in Humanitarian Action (GiHA) working groups to promote gender-responsive community engagement and trust-building in the design and implementation of COVID-19-related health risk mitigation and risk communication activities.

Safe and easy access to health facilities is not a given for Rohingya refugees. A little over half (57%) of the Rohingya reported that they can safely and easily access health facilities since the advent of COVID-19. This is consistent across gender and age groups. The biggest obstacle for Rohingya women in accessing health facilities was overcrowding. Other barriers

mentioned included insufficient income to pay for health care, distance of travel involved and cost of transport. As public transport was shut down and organizing private means of transport is more expensive than usual, the cost of travel has become a barrier to accessing health care. Men raised similar issues, as well as the fact that it was unsafe to travel to the health facilities because of Covid-19 and the problem of the associated containment measures. Health care is the priority need for women, girls, men and boys (see figures 3 and 4 below.).

Figure 3. Priority Needs or Concerns for Rohingya Community
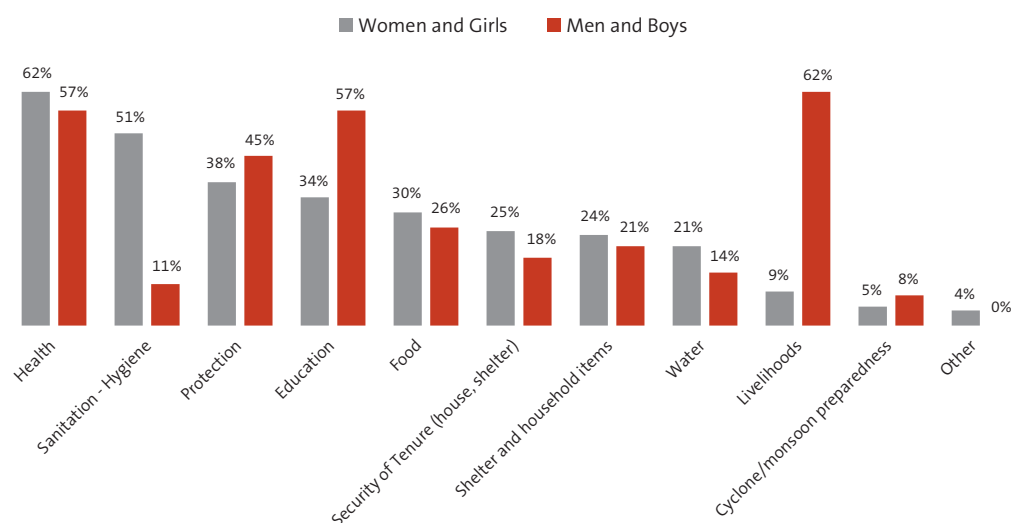
Figure 4. Priority Needs or Concerns for Host Community
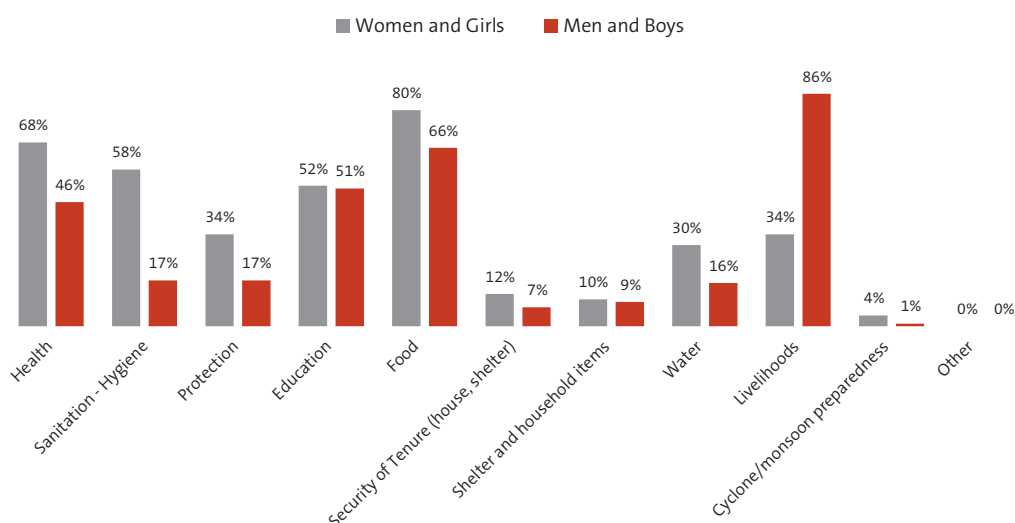
Host communities reported greater challenges to accessing health facilities, with only 40% reporting safe and easy access to health facilities. There were no big differences between gender and age groups. Barriers for women included distance and inability to pay for health care and transport to and from facilities. These were also barriers for men, but their main barrier was fear of being infected with Covid-19 at health facilities. Some key informants supported these findings, noting that the financial impact of Covid-19 had decreased the ability of poorer households to seek health services and be tested for the virus. Key informants also highlighted difficulties in accessing health services for non-COVID-19-related illnesses, even when these were critical.

Access to maternal, sexual, reproductive health and rights services is even more restricted for host community women. While 67% of Rohingya women reported being able to access these services, only 28% of host community women did so. For the latter, distance and cost were, once again, the main challenges. For the former, it was both distance and the lack of female staff at these facilities. One frontline worker reported that pregnant women cannot go to hospitals and be seen as quickly as before due to COVID-19. A frontline worker also reported an increase of women and adolescents who have been removing the Long Acting Reversible Contraceptives (LARC) due to beliefs related to Covid-19. Some frontline workers reported that treatment has often been delayed for pregnant women due to the COVID-19. Physical access is also difficult, both in terms of reaching and entering health facilities. Some frontline workers reported that pregnant women and others are afraid to go to the hospital with a cold or fever for fear of being found to be COVID-19 positive and sent to an isolation centre.

> **Pregnant women have to wait a long time in the hospitals to get vaccines. They are delivering babies at home as there is no transport to take them to the hospitals. People with chronic diseases cannot get better treatment because of the containment measures and such treatments are not available at camp hospitals.**

(Female, 24, Rohingya, CPJ Volunteer)

Stigma and discrimination hinder transgender persons' access to health. Violence and discrimination at health facilities was reported (see section on transphobic violence). Transgender informants reported needing to "tip" in order to receive health services and being attended to only after everyone else has been seen. This may dissuade transgender persons and other marginalized groups from seeking health care and disclosing COVID-19 symptoms. A few also reported no longer being able to access health facilities and hospitals, needing instead to get health care at organizations that work specifically on transgender issues, such as Bandhu Social Welfare Society and Lighthouse. However, there are only two centres serving all the camps which for many transgender persons makes accessing them very challenging.

Persons with disabilities also face challenges in accessing health, and 58% of persons with disabilities do not know where to seek health services and more than three quarters (84%) did not know what COVID-19 is.[28] This could limit their health seeking behaviour, even if experiencing COVID-19 like symptoms.

Most boys and girls (61%) do not know where to seek health services. Almost two-thirds (61%) know what COVID-19 is and one-third (37%) find information related to COVID-19 difficult to understand.[29]

Dissatisfaction and mistrust of health facilities explains difficulties of access for both communities. In Rohingya communities, fear of and dissatisfaction with health facilities were mentioned by women leaders and volunteers as a reason why people do not engage with these services, even when they are needed. Health services provided by humanitarian agencies in the camps are generally viewed negatively by the Rohingya, with high levels of dissatisfaction, distrust and scepticism about the quality. Response-wide quantitative and qualitative studies confirm that Rohingya households preferred paid health services, available outside of the camps to free services in the camps.[30]

Early on in the pandemic, it was found that despite positive experiences with health services, accounts of negative experiences were more prevalent and more likely to be widely shared.[31] Distrust is linked to reports of abuse at health facilities, especially of women, girls and transgender persons, as well as rumours around ineffective treatment. Interviews revealed similar findings for pharmacies, with reports of lack of stocks, price increases and unqualified pharmacists.

> **We have to wait in the hospitals as regular patients get medication first but the patients who are not frequent visitors have to wait a long time to see the doctor. They give only paracetamol. They check if the patients have a fever or not. If a person has a fever the service providers stay away. We want to complain to the higher-ups but there's no one.**

(Female, 50, CSO Leader)

Rumours and general negative perceptions of health clinics about the consequences of testing positive are likely stopping many from getting tested and seeking treatment. Many rumours were mentioned in the KIIs: from being killed and thrown into the sea to having

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28 Samaj Kalyan O Unnayan Shangstha. "*Coronavirus (COVID-19) Messaging for Children and Adults Living with Disabilities, Inclusive Survey*", July 2020.

29 Ibid.

30 ACAPS-NPM Analysis Hub, "*Rohingya Response - Health Behaviours and COVID-19. Analysis Hub*", 3 April 2020.

31 ACAPS-NPM Analysis Hub, IOM, "*COVID-19 Explained, Edition 6*", 31 May 2020.

their organs harvested or their food rations reduced. This led to a preference for pharmacies and unlicensed/traditional doctors over hospitals and clinics, including NGO-run facilities.

> " People are not going to the hospitals. Some believe if you go to the hospital and your COVID-19 test results are positive then you'll be killed. Some people are afraid about that. Some say it's better to stay at home than going to isolation centres because people are imprisoned in the centres and they won't get proper treatment and food there. A new rumour that some people started to believe is that Rohingya people who get COVID-19 will be sent to Bhasan Char. "

(Male, Rohingya, Head Mahji)

Reports of increasing mental health issues and a sense of insecurity and stress were high. Women are likely to experience high levels of stress and mental health issues due to the increase in GBV, household work and financial problems.[32] Men also experience stress, mostly due to the containment measures' impact on livelihood opportunities and the subsequent inability to provide for their families. The different types of stress experienced by men and women are interlinked and closely associated with gender norms and roles where feelings of being an inadequate provider can contribute to increased intimate partner violence (IPV).

The elderly and persons with pre-existing conditions were also mentioned by key informants as they are more vulnerable to the virus and thus cannot go outside. Finally, children and adolescents are impacted by the closure of educational facilities, with parents worried that this will impact their mental health and well-being. While these impacts are faced by both the host communities and the Rohingya, it will likely have a greater impact on the Rohingya, who already experienced psychological trauma from the targeted violence they experienced in Myanmar. This will also have a larger impact on those with existing mental health needs, including survivors of GBV, who are less able to access services and support during the containment measures.

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32 Samaj Kalyan O Unnayan Shangstha. "*Coronavirus (COVID-19) Emergency Response Messaging Rapid Host Community Survey - Final Report*", July 2020.
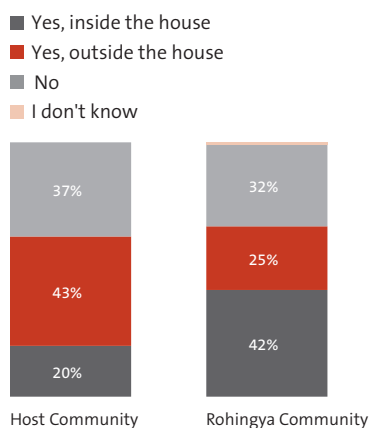
3.5   Protection

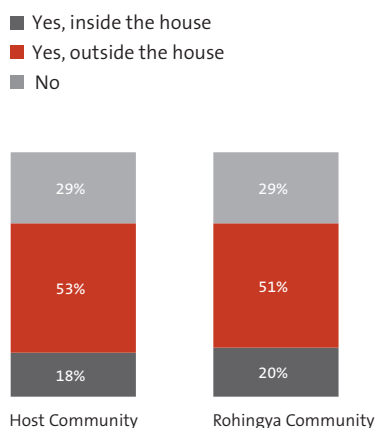| Findings	Recommendations
• Safety and security risks have increased during the pandemic for everyone, but pre-existing gendered risks have been exacerbated. Gender-based violence is increasing, including IPV, polygamy, transphobic violence and violence against female sex workers, while access to support is more restricted. • The different types of stress experienced by men and women are interlinked and tied closely to gender norms and roles where feelings of being an inadequate provider can contribute to increased IPV. • An increase in early, forced and child marriage due to financial pressure resulting from the containment measures has taken place, as well as a halt in education and livelihood services for girls and boys, access to women and girls' spaces, and the diminishing presence of camp authorities. Parents are mostly afraid that their children can fall victim to diseases and kidnapping. Children and adolescents are likely to experience the negative impacts on their mental health due to the loss of educational opportunities and the shutting down of safe spaces. • Increased stigma against transgender persons is occurring because social discrimination against them is based on the perception that that they are spreading the virus.	**Protection and GBV** **Urgent Priorities** 1. Increase community-based protection to ensure safe access to different services for women, girls and transgender persons. 2. Strengthen collaboration with the camp and legal authorities to improve security, including the safety of women and girls in the camps. 3. Work with local police and authorities to improve trust and ensure access to reporting for host and refugee communities. 4. Restore broader GBV services in camps and host communities and classify them as essential. 5. Train all first responders and frontline workers on dealing with GBV disclosures and referrals of GBV cases. 6. Ensure women, girls, men and boys have updated information on available GBV services and how to access these. 7. Ensure all staff and volunteers engaged in the COVID-19 response and wider humanitarian response are trained or retrained on preventing sexual exploitation and abuse. **Continuing Priorities** 8. Increase work on engaging men and boys, including religious and community leaders in consultations and awareness-raising with communities on preventing GBV, promoting a more gender-equal household dynamics, and reducing social stigma around women by breaking social norms and practices, for example, purdah. **Child protection** **Urgent Priorities** 9. Implement targeted community engagement approaches to reach high-risk adolescents, particularly adolescent girls and their families, to highlight concerns around early, forced and child marriage, child kidnapping, child labour and the short- and long-term implications of adolescent pregnancies. 10. Strengthen community engagement and risk communication efforts to ensure timely access of COVID-19 risk-prevention messages for children, including through providing guidance to parents/caregivers.

Overall Safety and Security

Most respondents, regardless of age, gender or legal status, reported that safety had decreased for women, girls, men and boys in both communities. The majority of host community respondents perceived safety risks to be greater for women and girls outside the home (43%), while Rohingya respondents have the opposite opinion and believe the risks for women and girls are greater inside the home (42%) (figure 5). Perceived risks for men's safety was thought to have increased outside the home (52%), regardless of the age, gender, or status of the respondent (figure 6).

Figure 5. Since the COVID-19 crisis, is it more unsafe for women and girls?

- Yes, inside the house
- Yes, outside the house
- No
- I don't know

	Host Community	Rohingya Community
No	37%	32%
Yes, outside the house	43%	25%
Yes, inside the house	20%	42%

Figure 6. Since the COVID-19 crisis, is it more unsafe for men and boys?

- Yes, inside the house
- Yes, outside the house
- No

	Host Community	Rohingya Community
No	29%	29%
Yes, outside the house	53%	51%
Yes, inside the house	18%	20%

During KII, some host community respondents mentioned that while women's movement was already restricted prior to COVID-19, currently men faced more restrictions. The Rohingya said they were concerned by the increasing levels of domestic violence against women and girls.

Theft was the main non-protection-related incident reported, a trend said to be increasing due to the financial hardship faced in both Rohingya and host communities.

> **Some crimes like theft have increased as the sources of income and scope of work have been reduced, so people cannot easily meet their needs. Domestic violence is also increasing due to the pandemic. Family disputes have arisen as families are stressed and there is a scarcity of goods to meet their basic needs.**

(Male, Host Community, Police Officer)

On the other hand, some KII reported that because of movement restrictions and people spending more time inside their houses, some crimes like robbery, and harassment, have decreased.

Most people reported any safety concerns to local authorities or community leaders. Men felt that they could still report issues to the relevant authorities despite imposed restrictions, while women were less certain. In Rohingya communities, both men and women prefer to report security issues to community leaders and majhis, followed by CiCs. Host community men and women prefer to report to local government and authorities, followed by family members. According to KIIs with police officers, people in host communities report violence and crimes to the local authorities and the police when they are committed outside the family, but crimes within the family are reported to family elders and community leaders.

Refugees believed that they could continue to access community leaders, majhis and CiCs during COVID-19 (74%), although men are slightly more confident about this (78%) than women (71%). Some female respondents mentioned that NGO protection services are less available or accessible than before, so they are relying more on the aforementioned authorities. Some respondents also mentioned that people are too afraid to report to the local authorities, e.g. the police, because they do not have money to pay them as they often ask for money.

> **First, go to the Majhi. Then go to the block committee, then to the Imam of the mosque. If the Majhi can't solve the issue then we consult with the block's Murobbi, if Murobbi can't solve the issue, then we go to the Imam. If the matter can't be solved there, then we go to the CiC to solve the problem. But the Majhi solves most of the problems.**
>
> (Male, 32, Rohingya, Frontline Worker)

The host community appears to have less access to their normal safety support, with only 52% believing they can still access these actors during the pandemic. This may be because many government offices were shut down for a long period due to the pandemic. Within the host community, the gender differences are stark: only 18% of women were confident they could access those responsible for safety, compared to 77% of men. This appears to support the point raised by Bangladeshi police officers that women can no longer seek support due to limited transportation, fear of moving around and the increased presence of men at home. Police officers noted that they received fewer requests, despite help desks and hotlines being open 24 hours a day, 7 days a week. They believe this is due to people being afraid, although it is unclear of what, or because people have limited faith in these services.

3.5.1 Gender-based Violence

Most key informants observed an increase in GBV, specifically IPV. The containment measures, movement restrictions and increased stress have led to a rise in domestic tensions, which often culminates in physical and emotional violence. Many KIIs pointed to men being confined at home as a source of this tension, as well as the additional household work. Reports of increased divorce rates were also mentioned, including incidents of men leaving their wives to get remarried.

> **Men cannot not go to work and in any case, there is no work. Because of the containment measures they cannot go out to the villages and earn money. They have to stay at home. They beat their wives. Women are suffering from the violence.**
>
> (Female, 24, Rohingya, CPJ Volunteers)

Respondents believe that the rise in IPV is primarily due to financial difficulties stemming from the containment measures. For men this is associated with a sudden change in lifestyle and the loss of their primary productive role as providers. As mentioned in the gender roles section, this is a major source of stress for men. As the economic impact is likely to continue beyond the pandemic, this increase in violence is unlikely to end soon and must be urgently addressed through short- and long-term strategies. However, it is important to remember that IPV and GBV was prevalent in both the Rohingya and host community prior to COVID-19.

Anecdotal reports of increased polygamy were noted. In other research, focus group discussions with Rohingya youth leaders and volunteers revealed that polygamy was reported alongside early, forced and child marriage, with girls being married to older, already married men who were less likely to demand a dowry. [33] This issue has been further explored in the child protection section. According to the Centre for Peace and Justice, youth volunteers have reported that women and girls in polygamous families have been facing difficulties during the pandemic as the husband can no longer move easily between his two households, resulting in one wife being more neglected.

Transphobic violence is also on the rise. Most transgender informants from both communities reported an increase of violence against them and their community linked to their gender identity. Three informants noted an increase in violence in health facilities, where they faced difficulties in accessing services. Violence and tensions were reported to be linked with their movement, with several transgender informants revealing that their movements have been highly restricted as communities will not allow them to return if they leave. Three out of six transgender key informants, from both Rohingya refugee and host communities, described

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33 The focus group discussions were held over WhatsApp on 1 July as part of a regular activity done by CPJ and BRAC University with their youth volunteers. The discussions on 1 July focused on gender concerns during COVID-19.

how they were being stigmatized and blamed for the spread of COVID-19. Actions against them include teasing, name calling and violence. Many felt that their movements were increasingly policed, with people refusing to let them enter their communities.

> **People ignore us more now than before. They call us 'Corona Virus' and say COVID-19 is coming, 'Get far away from me', people tell them. Community people do not like transgender people, and after the advent of COVID-19 they said that transgender people would not remain in our communities and if I say something violence occurs. They also said that they will tell armed groups to take me away.**

(Transgender, 21, Rohingya)

> **People think that we will spread COVID-19 as we go outside and see male strangers and move around. So now transgender people do not go to each other's homes due to fears of such talk and violence. Before we would visit the house where a wedding was taking place if they called us to dance. People gladly paid but now this activity has totally stopped. Our income source has totally dried up. People cannot come to my house. If any relatives/friends come to visit me, people ask me why they have come to my house. They don't like it. They don't want to rent houses to us.**

(Transgender, 45, Host Community)

The containment measures and its associated economic impact greatly reduced the ability of female sex workers to negotiate their protection. Key informant interviews with six female sex workers revealed an increase in exploitative behaviour by clients who refused to pay the agreed rate after using their services. They also struggle to negotiate the use of both protective gear for COVID-19 (i.e. masks) and contraceptives, with female sex workers reporting having to agree to what the client wants as they cannot afford to lose them.

While GBV cases are reported to be increasing, the pandemic and associated prevention measures have restricted access to support for survivors. Among other top priority needs for women and girls, 34% of women from host communities mentioned protection services compared to 19% of men. Among the Rohingya, 38% of women mentioned protection services compared to 53% of men. Host community women were also more likely to mention protection as a top priority for men and boys (32% of women compared to 17% of

men). However, among the Rohingya, 37% of women and 45% of men mentioned protection services for men. Rohingya women leaders and volunteers noted that protection services from humanitarian actors are no longer as available and accessible as before. Rohingya youth leaders and volunteers expressed concern about the lack of female police and army officers patrolling the camps, making it harder for women and girls to raise security concerns. As mentioned above, access to services, including security, has become more restricted for women and girls in Rohingya and host communities due to the containment measures, the increased monitoring of women's movement by men and fear of infection.

> **Intimate partner violence, domestic violence, sexual harassment and kidnapping have increased because of lack of security in the camp and because the number of organizations that work there has decreased. Vulnerable people are not getting proper help from the service centre. The CiC and CiC staff are not coming to the camp on a regular basis, so the bad people get the opportunity to perform abusive acts. When we are coming out of our homes men verbally abuse or tease us. Protection issues have increased. If anyone complains in any case it takes a long time to start procedures. Even sometimes the complaint is not taken properly from the service centre. The GBV services are being provided remotely and are not available everyday so it's difficult to access them. In fact, we are not receiving the services.**

(Female, 17, Rohingya, Youth Leader)

Other key informants expressed concerns about the perceived loss of confidentiality in accessing GBV support services due to movement restrictions, which makes them more visible or more likely to have to inform household members.

3.5.2 Child Protection

Rohingya youth volunteers reported an increase in the marriage rate for girls below 18 years. Boys also seem to be at risk. The increasing rate in early, forced and child marriages was attributed to the financial pressures faced by families, as well as a desire to keep girls safe. Other explanations included the fact that marriage is pushed as an alternative milestone to education or work, both of which have been halted by the containment measures. Adolescent girls can no longer access women and girls' friendly spaces and learning centres where they previously received support and capacity-building opportunities. Another more worrying explanation was the diminished presence of the camp authorities, which has

reduced oversight of marriages.[34] As pointed out in the first RGA, the closure of temporary learning centres and schools, the partial closure of child-friendly centres, except for individual case management and counselling services, and increased household tensions are leaving children and adolescents at a greater risk of abuse, neglect and violence.[35]

Changes in rates of early, forced and child marriage in host communities were not reported, although these may also be increasing. A SKUS survey in host communities found that early, forced and child marriage was the second highest concern respondents had for a girl, second only to kidnapping.[36] Similarly, 69% of respondents mentioned this phenomenon as the main social issue they faced in their communities. As noted in the national Rapid Gender Analysis, it is often used as a coping mechanism during financially difficult times, and therefore the rate of such marriages is likely to increase as the economic situation worsens. Fathers were seen as the main decision-maker for early, forced and child marriage, sometimes in consultation with elders from their household or community.[37]

Strategies to end the practice, such as adolescent girls' empowerment, community mobilization, education, life skills and adolescent-friendly health services, have been disrupted by the pandemic despite their importance. Longstanding research shows that early, forced and child marriage leads to lower educational attainment, higher rates of IPV, increased adolescent pregnancies and poorer health in infants born to children, issues that are exacerbated in the current situation as sexual reproductive health services have been reported to be harder to access since the advent of COVID-19.

Disease and kidnapping were the main fears parents had for their children in the Rohingya community.[38] Parents were also concerned about drug use among boys and sexual violence against girls. As learning facilities are closed, children are no longer occupied and are more likely to be outside, and therefore increasingly exposed to risks such as kidnapping and human trafficking. For the host communities, kidnapping was also the main concern for both boys and girls, while early, forced and child marriage was the second concern for girls and drug use among boys.[39]

Children and adolescents are likely experiencing negative impacts on their mental health from the loss of education and play. Key informants, especially Rohingya women, were worried about the mental state of children who can no longer go to school and must stay at home all day. Focus group discussions[40] with Rohingya youth leaders and volunteers revealed

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34 Ibid.

35 Inter-Sector Coordination Group, "*Covid-19 Response Plan: Addendum to the Joint Response Plan 2020 - Rohingya Humanitarian Crisis (April - December 2020)*".

36 Samaj Kalyan O Unnayan Shangstha. "*Coronavirus (COVID-19) Emergency Response Messaging Rapid Host Community Survey - Final Report*", July 2020.

37 Toma, I. et al., "*Rohingya Refugee Response Gender Analysis: Recognizing and Responding to Gender Inequalities*", 1 August 2018.

38 Samaj Kalyan O Unnayan Shangstha. "*Coronavirus (COVID-19) Rapid Survey of Rohingya Community*", July 2020.

39   Samaj Kalyan O Unnayan Shangstha. "*Coronavirus (COVID-19) Emergency Response Messaging Rapid Host Community Survey - Final Report*", July 2020.

40   The focus group discussions were held over WhatsApp on 1 July as part of a regular activity done by CPJ and BRAC University with their youth volunteers. The discussions on 1 July were focused on gender concerns during COVID-19.

their own anxiety around the lack of educational opportunities during COVID-19 and what this will mean for their future. Among the Rohingya, 68% of respondents noticed a change in their child's behaviour since the onset of the pandemic, including mood swings and anger.[41] In host communities, the number was lower, but over a third (37%) of respondents noticed a change in their children's behaviour since the start of the crisis.[42]

3.6   WASH

Findings	Recommendations
• Difficulty accessing WASH services has increased among Rohingya refugees. Difficulty accessing adequate amounts of water required to maintain personal hygiene was due to lack of water storage systems and containers, the distance to water sources, wait times at water points and delays in WASH services. Women and girls face issues of overcrowding and lack of privacy when using latrines during the day, while at night they risk harassment and violence due to inadequate lighting. • Most women within the host community do not the challenges noted by Rohingya women. • MHM has become more difficult during the pandemic due to delays in distribution of materials. Additionally, it has become much harder for women and girls to wash and dry their menstrual cloths due to taboos around menstruation. This has resulted in women and girls reusing wet menstrual cloths despite the risk of infections.	**Urgent Priorities** 1. Increase the provision of safe and sufficient water access in camps for women and girls as it is their primary responsibility to collect water and maintain hygiene in the home. 2. Increase and continue latrine and bathing facility maintenance and repair work, including by integrating minimum standards on gender and protection. 3. Provide protective and hygiene equipment (masks, soap, hand sanitizer) to poorer households who cannot afford it, including female sex workers and transgender persons in host communities. 4. Due to changes in privacy around COVID-19, support Rohingya and host community women with MHM, including exploring alternative products to avoid issues of washing and drying menstruation cloths. 5. Designate space for the washing and drying of menstrual clothes in women-only bathing facilities and the provisions of appropriate disposal services. 6. Prioritize engaging women in the production of reusable menstrual products along with masks in camp-based income-generating/self-reliance activities and ensuring women and girls have access to these products. **Continuing Priorities** 7. Ensure gender-specific safety measures are taken around WASH facilities, including reducing crowding, providing sufficient light at night, locks, among other measures. 8. Ensure availability of required equipment and facilities for persons with disabilities and older people to maintain hygiene-prevention measures.

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41   Samaj Kalyan O Unnayan Shangstha. *"Coronavirus (COVID-19) Rapid Survey of Rohingya Community"*, July 2020.

42   Samaj Kalyan O Unnayan Shangstha. *"Coronavirus (COVID-19) Emergency Response Messaging Rapid Host Community Survey - Final Report"*, July 2020.

According to the results of the survey, refugee women reported having insufficient water to meet their daily needs given the increased water required to maintain personal hygiene. The main reasons cited were lack of water storage and containers (30%), distance (28%) and wait times at water points (21%). These findings were echoed by 49% of men as well. The difference in responses between women and men is linked to the fact that women are the primary water collectors in the family. During the KIIs, many Rohingya women leaders and volunteers reported water scarcity and delays in WASH services as concerns, including lack of soap. One frontline worker described the change in distribution modalities for soap, which is now delivered door-to-door, as causing delays in the delivery process.

A total of 38% of women and 49% of men reported that access to latrines and bathing facilities has worsened, while only 5% of both women and men reported that access had improved. Interviews with Rohingya women leaders and volunteers highlighted issues with WASH facilities, especially latrines, some of which are reported to be damaged. Rohingya youth volunteers raised concerns that women and girls face issues of overcrowding and lack of privacy when using latrines during the day, while at night they risk harassment and violence due to inadequate lighting. A little over half of Rohingya women reported their sanitation and hygiene needs as a priority, second only to health care (see figure 3 on page 29). Frontline workers, some community members and a Maji reported a decrease in WASH maintenance activities, like fixing broken hand pumps, bathing cubicles and toilets, and in desludging activities and cleaning dustbins and drains.

> **WASH activities have decreased, they used to fix broken hand-pumps, bathing cubicles, toilets and used to dislodge toilets. Now WASH teams are not repairing broken hand-pumps or dislodging and cleaning the toilets. Rohingya people cannot do the repairs. The drains are dirty too. Several kinds of diseases may break out because of that. There is a dire need of such support. Streetlights near the toilets are not functioning, and no one comes to repair the lights even after contacting the hot lines. It is difficult for women to use the latrines at night.**

(Male, Rohingya, Head Mahji)

Based on the results of the survey, host communities seem to have adequate access to enough water to meet their needs and have not faced increased difficulties in accessing latrines and bathing facilities. Those who reported that they could not access sufficient water resources, about one third of respondents, said it was primarily due to the distance of water points or because of water shortages. In regard to latrines and bathing facilities, 94% of women and 86% of men reported no change in access. A possible explanation for

this is that men were accessing latrine and bathing facilities in higher numbers prior to COVID-19.[43] As many women and girls use makeshift latrines/showers in their shelters, they may possibly be less likely to identify changes in access.

MHM has become more difficult during the pandemic. Forty-three percent of Rohingya women and 40% of host community women reported not having enough menstrual hygiene products to meet their needs since COVID-19 (see figure 7). Gaps in MHM were observed prior to COVID-19, with almost a quarter of households not receiving menstrual hygiene materials regularly enough.[44] Female Rohingya informants voiced distress over the lack of sufficient MHM support during the containment measures, noting that the distribution of products had been stopped or limited. One KII highlighted that as male relatives now stay at home because of the containment measures, it has become much harder for women and girls to wash and dry their menstrual cloths due to the taboo around menstruation, which does not allow them to do so publicly. This has resulted in women and girls reusing wet menstrual cloths despite the risk of infections.

Figure 7. Since COVID-19 have you received enough menstrual hygiene products to meet your needs?

■ Yes ■ No

	Host Community	Rohingya Community
No	40%	43%
Yes	60%	57%
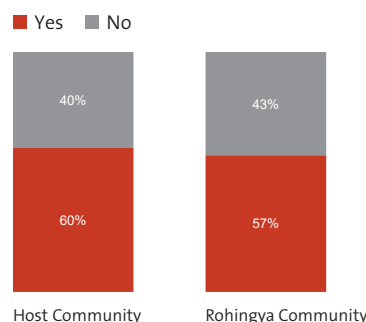
> **We have a shortage of water so it's difficult to keep washing both hands and to observe menstrual hygiene. Male family members are staying at home, so for women and girls drying the menstrual cloth during menstruation is a problem. They cannot dry it properly, so they have to use a wet cloth which puts women and girls at risk of infection.**
>
> (Female, 17, Rohingya, Youth Leader)

KII with persons with disabilities indicated their worry that decreased WASH maintenance activities make them more prone to falling sick from other diseases.

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43   UNICEF and REACH, *"Key findings from Quantitative and Qualitative Data Collection: Joint Child Protection Sub-Sector Assessment"*, 2020.

44   Ibid.

4 CONCLUSION

The impact of COVID-19 on the Rohingya and host communities varies depending on the social attributes and circumstances, but the situation has worsened for everyone. The pandemic and containment measures have exacerbated existing discrimination and inequalities. Women and girls face an increase in unpaid care work, greater protection risks in and out of their homes and more mental health issues while simultaneously being less able to access lifesaving services and support. Vulnerable groups and those that were already marginalized and excluded have all faced greater challenges and risks.

Understanding how social characteristics, such as gender, age, disability status, or gender identity, along with the rigid social norms in both communities and the decreasing basic services play a role in a person's ability to protect themselves and recover from the secondary impacts of COVID-19, is crucial to ensuring a response that does not leave the most vulnerable behind. The COVID-19 addendum to the Joint Response Plan for 2020 highlights some of these inequalities and aims to address them through the sectors' strategies.[45] The Joint Response Plan for 2021 must go further in ensuring an inclusive and fair response for Rohingya and host community women, girls, men and boys and transgender persons.

COVID-19 has impacted everyone's ability to meet their basic needs, but those with existing vulnerabilities based on social characteristics and gender norms face greater challenges. Prevention measures, including containment measures and movement restrictions, have had dire consequences on Rohingya and host communities' livelihood opportunities and their access to services and resources.

Achievements in gender equality and in the empowerment of women and girls are being undone by COVID-19 and the associated preventive measures, specifically in terms of meeting their basic needs (menstrual hygiene or sexual reproductive health), ensuring their safety and empowering them to participate and lead in the response.

Safety and protection risks have increased for everyone, but GBV, including early, forced and child marriage and transphobic violence, were the main risk. Yet pre-existing gendered risks expose women and girls, men and boys to different forms of vulnerabilities.

Women, men and other vulnerable groups are willing to participate in the COVID-19 response, but several actors involved in the response have not engaged with them, nor do they always have the channels to do so. Women leaders, first responders and those from vulnerable and marginalized communities must be officially recognized, visible and actively involved in the response at all stages.

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45   Inter-Sector Coordination Group, "*Covid-19 Response Plan: Addendum to the Joint Response Plan 2020 - Rohingya Humanitarian Crisis (April - December 2020)*".

Gender norms and roles have barely changed during the pandemic, with decision-making powers still firmly controlled by men and tied directly to income-generation. COVID-19 may have a negative impact on how women and girls negotiate the restrictive social norms that govern their lives, given that COVID-19 has further restricted their mobility in public spaces, confining them further to their homes, and also increasing social stigma and GBV in all forms.

Rohingya women outreach volunteers in front of UN Women/AAB Multi-purpose women centre in camp 18. Photo Credit: Pappu Mia.

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