COVID-19 OUTBREAK: COX'S BAZAR RAPID GENDER ANALYSIS

May 2020

Developed by the ISCG Gender Hub in collaboration with UN Women, CARE and Oxfam.

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Acknowledgements

This Rapid Gender Analysis has benefitted from the valuable contributions of members of the Gender in Humanitarian Action Working Group, Gender Focal Points and Sector Coordinators.

Cover photo: Rohingya woman making masks in a UN Women-BRAC Multi-Purpose Women Centre, April 2020. Photo Credit: UN Women/Nadira Islam.

The ISCG Gender Hub is supported by the generous contribution of the Government of Canada.

COVID-19 Outbreak: Rapid Gender Analysis

Abbreviations

CiC	Camp-in-Charge
COVID-19	Novel coronavirus 2019
GBV	Gender-based violence
MHM	Menstrual hygiene management
MHPSS	Mental Health and Psychosocial Support Services
MSNA	Multi-Sector Needs Assessment
REVA	Rohingya Emergency Vulnerability Assessment
RGA	Rapid Gender Analysis

Executive Summary

The Novel Coronavirus 2019 (COVID-19) pandemic has had a devastating impact and is expected to have lasting consequences globally. As of 4 May 2020, 10,143 cases have been confirmed in Bangladesh. To date, only 21 cases have been identified in Cox's Bazar district, which is home to over 850,000 Rohingya refugees and extremely vulnerable host communities. Although no positive COVID-19 cases have been reported in the camps, this is likely to change soon. The conditions in the camps, including overcrowding, limited sanitation facilities and an overburdened health system, have made the COVID-19 preparedness and response plan uniquely complex. An inability to fully meet basic needs, low levels of nutrition and limited access to health care may have had a damaging impact on the immunity levels of Rohingya refugees, making them more vulnerable to the virus.

A COVID-19 outbreak in the refugee camps and neighbouring communities would disproportionately affect women and girls and other vulnerable populations. Gender norms and roles in both refugee and host communities are likely to limit the ability of women and girls to protect themselves from the virus, and, if not adequately taken into account, they will have a significant impact on prevention and response efforts. Special attention to reduce risks must be accorded to older women, women with existing medical conditions and to pregnant women with a lower immunity status.

KEY FINDINGS

- The normative framework that governs the lives of Rohingya refugees unequally affects women and girls by limiting their mobility, their ability to make decisions about their lives and access lifesaving services, and deprioritizes their needs and demands compared to those of men.
- Restrictive sociocultural gender norms, gender-based violence, lack of gender-responsive facilities and services and security threats have hindered the ability of women and girls to meet their basic needs.
- The COVID-19 crisis and lockdown measures will exacerbate these pre-existing social and gender norms with negative consequences for women and girls, as men may use the new restrictions and lockdown measures to exert their power and further control women and girls' mobility and access to services.
- The unpaid care work of women and girls has increased due to COVID-19 and related preventative measures, including caring for children, collecting water and maintaining household hygiene.
- As primary caregivers in households and as frontline workers, women are at high risk of exposure to the virus.
- Women are excluded from decision-making systems in the community, and their lack of access to reliable information, consultations and feedback mechanisms limits their ability to influence both prevention and response plans.
- The inclusion of women leaders, networks and volunteers in the planning, implementation and monitoring of response plans will have a strong impact on making these right-based strategies, inclusive and effective.
- Religious beliefs and practices play an important role in the life of Rohingya refugees,

therefore, if these are not properly taken into account in response plans, failure to include them may have strong implications for both men and women.

- Confinement, a rise in tensions and restrictions on services and access for humanitarian workers will increase levels of gender-based violence (GBV), child abuse and neglect and sexual exploitation and abuse.

The Rapid Gender Analysis provides recommendations to the sectors on how to address the gender implications of COVID-19 in their response plans. Overall, recommendations for all humanitarian and government actors are as follows:

- **Collect and analyse sex, age and diversity disaggregated data** on infection rates and prevention and response activities, and **regularly conduct gender analysis to understand the differentiated impact of COVID-19** on women, girls, men, boys and other vulnerable populations.
- **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.
- **Ensure women and girls are consulted and that they assume meaningful decision-making and leadership roles** in the planning and implementation of COVID-19 preparedness and response activities.
- **Engage women volunteers, women leaders and women's network**s to reach out to women and girls.
- Design all prevention and response activities and messages with the aim of **mitigating the burden on women and girls** in terms of the **additional time they** take in doing unpaid care work.
- Ensure **all women frontline workers have sufficient information, services and tools to protect themselves and their families**.
- **Prepare for, mitigate and respond to a potential backlash against women** based on social and religious norms.
- Ensure an **adequate number of female volunteers and frontline workers** are in place to share information with and provide services to women and girls in a socio-culturally appropriate way.

Objectives and Methodology

COVID-19, which was detected in China in December 2019 and has since spread to over 180 countries and territories, was declared a global pandemic on 11 March 2020. As of May 4, 3,435,894 cases had been confirmed, with 239,604 deaths recorded globally[1]. The first case of COVID-19 was officially confirmed in Bangladesh on 8 March, with a total of 10,143 confirmed cases and 182 recorded deaths in the country since then[2].

Over 850,000 Rohingya refugees live in the Cox's Bazar district in Bangladesh, many of whom arrived in August 2017 following an increase in targeted violence in the Rakhine State, Myanmar. These refugees, 52 per cent of whom are women and girls, live in 34 extremely congested camps, relying almost fully on humanitarian assistance to meet their basic needs. Host communities around the camps are some of the poorest in the country, with low education, health and food security indicators[3]. The rapid influx of refugees has put significant pressure on services, infrastructure and the environment in these communities, affecting their livelihoods and access to

basic services. Currently, only 39 cases of COVID-19 have been confirmed in the district, with no cases identified in the camps[4]. Government and humanitarian actors have taken rapid measures to prepare for a possible outbreak in the camps and surrounding communities.

Evidence emerging from the pandemic and previous health crises have highlighted the gender differences in the way women, men and persons of other gender identities are impacted. Gender norms, roles and discrimination affect the way people can protect themselves from the virus. Other characteristics, including age, disability or legal status also have an effect on the way people cope with this virus. Without taking into account the effects and implications of gender and social characteristics, preparedness and response plans to COVID-19 will not be effective.

The Rapid Gender Analysis (RGA) for COVID-19 provides information about the different needs, risks, capacities and coping strategies of women, men, boys and girls in the crisis. The evidence-based information offered by the RGA should be used to support efforts to design inclusive and effective plans and interventions that leave no one behind. The objectives of this RGA are as follows:

- To analyse and understand the different impact that COVID-19 will have on women, girls, men and boys and other vulnerable populations, and to understand how gender norms and roles will affect the outbreak, prevention and response.
- To inform the preparedness and response plan for COVID-19 and provide targeted recommendations for the sectors to address the particular needs of women, girls, men and boys and other vulnerable populations.
- To inform the second RGA that will be undertaken through collecting primary data in the camps and host communities.

This RGA was developed between the 12-23 April 2020 and is based on a secondary data review of country-level and response-level resources from humanitarian organizations, sectors, and government. Its constraints therefore reflect the limitation of these resources, including in coverage and analysis.

Demographic Information

The general immunity of the Rohingya population is predicted to be lower than that of the general population

With over 45 per cent of refugees having unacceptable food consumption scores, facing overburdened health services and overcrowding and poor hygiene conditions in the camps, Rohingya refugees are more likely to have lower immune systems and be at greater risk of transmitting and contracting COVID-19.

Underlying conditions and the age factor put certain groups at even higher risk

While the demographics of the camps is skewed towards youth, with 54 per cent of the population under 18 years, over 30,000 (4 per cent) Rohingya refugees are over 60 years (with a slightly higher number of women), and 30 per cent of them require assistance to complete their daily activities[5]. Around 0.5 per cent of refugees suffer from a serious medical condition, and 1 per cent live with some form of disability. Both of these categories involve higher numbers of women[6].

While gender does not appear to have a direct impact on contracting the virus, it is likely that there will be direct and indirect social, economic and psychological impacts on women and girls and specific at-risk groups. For example, female-headed households tend to have poorer indicators in terms of nutrition or access to sanitation and health[7], which is likely to impact their preparedness and response to the virus. Female headed-household account for 28 per cent of all households, while numbers of single parents/caregivers remain low (1.2 per cent of all individuals), with 90 per cent being women[8].

The average household size in Rohingya and host communities are similar, 5.1 and 5.6 persons respectively, although Rohingya households had a higher ratio of dependents to working-age adults[9]. However, the prevalence of polygamy in both communities will likely have an impact on the way polygamous households quarantine and may increase the risk of transmission if the husband moves from one household to another.

Age	Female	Male	Total
0-4 yrs	79,962 *9.3%*	80,822 9.4%	160,784 *18.7%*
5-11 yrs	91,999 *10.7%*	97,158 *11.3%*	189,158 *22%*
12-17 yrs	57,607 *6.7%*	58,467 *6.8%*	116,074 *13.5%*
18-59 yrs	200,335 *23.3%*	161,644 *18.8%*	361,979 *42.1%*
60+ yrs	16,336 *1.9%*	14,617 1.7%	30,953 *3.6%*
Total	446,240 *52%*	412,708 *48%*	859,808

Demographics of Rohingya Population in Refugee Camps in Cox's Bazaar, Bangladesh[10]

Age	Female	Male	Total
0-17 yrs	133,200 *30%*	146,520 *33%*	279,720 *63%*
18 + yrs	82,140 *18.5%*	82140 *18.5%*	164,280 *37%*
Total	215,340 *48.5%*	228,660 *52.5%*	444,000

Demographics of Affected Host Community Population in Cox's Bazaar, Bangladesh[11]

Gender Norms, Roles and Relations

The gendered implications of COVID-19 must be understood within the overall framework of gender norms, roles and relations that is the foundation of the society Rohingya refugees live in. The gender-related differentiations that can be observed in the Rohingya refugee crisis arise because of the high prevalence of gender-based violence (GBV) and the socially restrictive norms that limit women's access to all public spheres, including access to healthcare and WASH services, information, relief distribution, decision-making, income-generation and all forms of community engagement. The Rohingya's understanding of *izzot,* or "honour", has specific gender-related implications for women and operates as a normative system of control that shapes women's status and roles within their families and communities, including their freedom, rights, agency and mobility.

A woman's *honour* is something that is policed, assessed and evaluated by social norms reference groups in the community, in particular male heads of households, community leaders and religious leaders, in terms of what is acceptable for a woman to do[12]. The practical application of this is the widespread practice of *purdah (*seclusion of women from public observation/spaces), which is

practiced in various stages of a woman's life when her, and in turn her family's honour, is perceived as being at risk[13].

As with every crisis context, pre-existing gender norms are often exacerbated with negative consequences for women and girls. Activities by women perceived as "dishonourable" (breaking the practice of purdah) are already being cited by women and men in Rohingya camps as a reason for the COVID-19[14]. These gendered perceptions and the increased social stigma against women may lead to increased policing of women, further reducing their access to services and information, freedom of movement and overall empowerment and subjecting them to various forms of GBV.

COVID-19 is increasing the unpaid care work for women and girls

The household division of labour appears to be relatively static in Rohingya families in the camps, and, despite some reported increase in men's participation, women are primarily responsible for performing household and care work roles[15]. This was reported to be extremely unbalanced, with women spending ten hours a day on unpaid work compared to one hour for men[16]. Daily activities for all women include cooking, cleaning, care work and water collection, with half engaging in homestead gardening, according to a recent study conducted by CARE, the Office of the United Nations High Commissioner for Refugees (UNHCR) and ActionAid Bangladesh[17]. In comparison, only half of men reported spending time on household and care work such as childcare, caring for a relative and collecting water[18].

Adolescent and young girls are also responsible for part of the household work. A majority of adolescent girls reported cleaning, cooking and taking care of family members in a typical day even during the COVID-19 pandemic and lockdown measures[19]. For host communities, the division of unpaid care work were largely similar, with women responsible for all the care work, and girls supporting them[20].

Women's caregiving role of children and sick family members will increase their risk of infection

Women's caregiving role has an impact on their ability to protect themselves from COVID-19. Consultations with Rohingya women and adolescent girls emphasized the primary concern of women remains the well-being and safety of their family members, particularly their children[21]. Reports from consultations with women highlighted that they would not be willing to be separated from their children as they must take care of them. They would therefore need to isolate with their children if sick or would refuse to shield themselves or go into self-isolation, despite understanding the risks this entails[22]. The inability to maintain their duty as primary caregivers in the household if women have to self-isolate was perceived as a source of stress and one of the main reasons for their reluctance to access these facilities[23].

Participation, Decision-Making and Leadership

Gendered decision-making power in the household will impact COVID-19 prevention and the response, and put women and girls at further risk

Power in the household, as in the community, is primarily held by men, despite changes in gender roles since displacement and efforts from the humanitarian community to promote women's empowerment and leadership. Men, especially older men, are the main decision-makers in the family, taking decisions on household-related issues, such as food and asset purchases in both

refugee and host communities[24]. Household income is predominantly controlled by men, with less than half of male refugees allow their wives to equally share the income[25].

In contrast, men from the host community were more willing to share income with their spouses, with a majority of them reporting doing so[26]. Men also have decision-making power over issues that directly affect women and girls, such as their ability to move around the camps and go to distribution points, as well as seek and access services[27]. This impacts their ability to access aid and has resulted in women and girls not equally benefiting from humanitarian aid[28].

This also impacts their health and safety, with over half of Rohingya households and almost half of host community households identifying men as the ones deciding where women should give birth[29]. With COVID-19, male household members may delay access to health care for women and girls, especially those not exhibiting serious symptoms. Overall mobility of women and girls may be further restricted by male household members, as a protection and control measure, impacting their ability to meet their basic lifesaving needs and access critical information and services including GBV services, sexual and reproductive health care, information or menstrual hygiene management, among others.

Age is a factor in decision-making power and affects girls' and boys' access to services and resources

Decision-making power in the household is also dependent on other social characteristics, specifically age. Research conducted by Oxfam reported that respondents saw the oldest adult male in the household as the family representative[30]. Qualitative findings from a gender analysis conducted by CARE, UNHCR and ActionAid Bangladesh showed that only a few Rohingya men occasionally consulted their wives and eldest son, but none of them considered consulting their daughters and younger sons[31].

Unmarried young girls barely have any opportunities to participate in household decision-making compared to their married counterparts who may participate in decision-making in consultation with their husbands, although as expressed by a boy participant of the analysis: "My mother has to take permission from my father for everything. Mother cannot even visit anywhere alone but takes us with her"[32].

Gender differences in decision-making power are also seen in adolescents. While almost all adolescent girls (94 per cent) reported taking permission from their husband, father or mother to access medical care, only 29 per cent of adolescent boys reported the same[33]. Finally, fathers were also predominantly seen as the main decider for early/forced marriage of their children, sometimes in consultation with elders from their household or communities[34], which will likely increase as a negative coping mechanism during the COVID-19 crisis.

Women's lack of participation and leadership in the community will be replicated in the COVID-19 preparedness and response plan

Camps are run by camps-in-charge (CiCs) who report to the Refugee, Relief and Repatriation Commissioner. None of the CiCs are women, although there is one female assistant CiC in the camp 4 extension. The CiCs work with Rohingya leaders, such as *majhis* and, more recently,

elected block leaders in the few camps (Camp 4 Extension, Camp 20 Extension, Nayapara and Kutupalong registered camps) where pilot elections have taken place.

The *majhi* system was established by the Government of Bangladesh after the 2017 influx to assist in linking Rohingya refugees with emergency assistance. As the system was put in place without participation from the Rohingya community, consequently not a single representative of the population is included. In fact, it is made up of almost exclusively middle-aged men and there are very few exceptions of camps where women have also emerged as elected or self-mobilized community leaders[35]. Thirteen camps have Gender Officers, established by UN Women, who are seconded to CiCs to support addressing gender issues. These six national staff are supported by 40 Rohingya volunteers (50 per cent women, 50 per cent men) who are able to directly reach and engage with Rohingya communities.

Structural and institutional factors constrain women's leadership and participation. Challenges include lack of family support and resistance from husbands, burden of household and caregiving work, lack of education and low self-confidence[36]. Elected female leaders also raised issues of rampant gender stereotypes, difficulties in building alliances with other decision-makers and the lower importance given to female leaders[37]. Sociocultural and religious beliefs and values in the community led to intense resistance to women's participation in public life, let alone in leadership roles.

This resistance has come from the communities, sometimes reinforced by imams and other religious actors, *majhis,* male relatives and other women, who view women's participation in public life a threat to maintaining the practice of purdah, clashing with the feminine ideal and therefore jeopardizing the family's *izzot* (honour)[38,1]. These trends around women's leadership and participation will continue into the COVID-19 response, if no concerted efforts are made to include women.

Including women leaders and women's networks in the planning and implementation of the COVID-19 response will improve its effectiveness

This lack of representation in community leadership and decision-making led to women self-organizing into groups, and running and voting in camp elections held in 2019. Almost half of leaders in the few camps that held elections are women, including women with disabilities[39]. Consultations with women and girls in camps where voting has yet to happen showed that the majority believed women would be good leaders and able to represent their issues[40]. In camps where female leaders had been elected, consultations with women and girls validated these assumptions, highlighting that the liaison with the humanitarian sector improved the situation thereby leading to a greater recognition of their rights and needs[41].

Women's networks and self-organized groups have been instrumental in implementing activities on the ground and reaching women and girls, in both Rohingya and host communities. As part of the COVID-19 response and preparedness efforts, these women's networks and groups in camps and host communities have been leading community outreach and awareness-raising messaging,

[1] It must be noted that women who are married, widowed, or older, and with more than one child, have greater access to leadership opportunities and could maintain a less strict version of purdah, as they face less threat to their izzot; in fact most female leaders in the camps are older with more than one child.

consultations, and well as engaging women in their communities in the production of cloth masks that are then distributed to community members and volunteers. Without supporting women's leaders and networks to reach out to women and girls, they will largely be excluded from the planning and implementation of the response, dramatically reducing its effectiveness and risking leaving half the population behind.

Livelihoods

Limited livelihood options for women can significantly reduce their ability to protect themselves

According to REVA II, 88 per cent of the Rohingya population are highly or completely dependent on life-saving assistance[42]. Some women and men have been able to access income-generating opportunities, such as informal day labour outside the camps, running a small business inside the camp, or working as a volunteer and cash-for-work at NGOs for men and volunteer or cash-for-work for women[43]. However, the numbers remain very small and significantly skewed towards men: only 2 per cent of women were engaged in an income-generating activity compared to 27 per cent of men[44,2]. Similar findings are related for adolescents, where 44 per cent of adolescent boys (aged 15 to 20) reporting working outside the home compared to 7 per cent of adolescent girls[45].

Female headed households and household without adult males are also less likely to access these activities: male-headed households are twice as likely to have one adult member working compared to female-headed households, while only 8 per cent of households without adult males had one member working compared to 55 per cent of households with an adult male[46]. For host communities, the gender differences in access to income-generating activities is even more significant, with 47 per cent of men compared to 4 per cent of women are engaged in such activities[47].

Female labour force participation rates are lower in both Teknaf and Ukhiya upazilas than the national average[48]. Women who are working in host communities are often engaged in the informal economy, which offers little to no social or employee protections, and will therefore be unlikely to obtain financial support during the lockdown. Lack of access to or loss of income sources due to the lockdown measures will make it harder for households in both Rohingya and host communities to purchase necessary materials and equipment to protect themselves, including soap or masks.

Financial impact of COVID-19 will increase GBV

Increased economic vulnerability may result in a rise of household tensions and domestic violence, which affects women and girls almost exclusively. This may also lead to negative coping mechanisms and GBV, including early/forced marriage and trafficking of women and girls.

[2] Nevertheless, Rohingya women's engagement in productive roles represent a significant shift in social and gender norms, although this opportunity has not been universal across all women and all camps. Access to financial resources have been used by some women as a bargaining chip to ensure approval from male relatives and the community in engaging in activities outside the home. While women do welcome work opportunities, they prefer to do so in a dignified and safe manner, to be able to maintain purdah and avoid any backlash and policing from their families and communities. (Source: International Organization for Migration (IOM) and UN Women, 2020)

Other vulnerable populations have been financially impacted by COVID-19 which limits their ability to protect themselves

Transgender persons, many of whom rely on begging or selling sex, as well as sex workers, are especially vulnerable during the lockdown. As a majority of them are entirely dependent on their daily work, most are already facing financial challenges[49]. This limits their ability to purchase necessary protective equipment, sufficient food or to access health services.

New and existing livelihoods opportunities in the camps has allowed women to generate an income while supporting COVID-19 prevention activities

Women-friendly spaces had previously offered opportunities for some women and adolescent girls to take part in training and livelihood opportunities, such as tailoring and producing reusable sanitary pads. In light of the COVID-19, and with restrictions on access to women-friendly spaces, many have reconverted to producing masks that can be used by themselves, their families and other volunteers working in the camps to protect themselves from COVID-19. Consultations with women and adolescent girls conducted by UN Women highlighted the importance for women and girls to feel that they are participating in preventing COVID-19, including through mask production[50].

Many women in host and Rohingya communities are engaged in homestead gardening, providing them and their families additional sources of nutrition[51]. As food distribution in the camps has become less varied, and with shops closed or with a more limited variety of items available, homestead gardening can support families to continue to access nutritious food and to supplement their diets.

Basic Needs

Food insecurity puts women and girls at higher risk of infection

The second Rohingya Emergency Vulnerability Assessment (REVA), conducted by the World Food Programme in 2018, found female-headed households most likely to have inadequate diets (together with small-size households and households with high dependency ratios)[52]. Similarly, households headed by women or with no adult male (aged 18-59) were less likely to have an acceptable food consumption score, making them more vulnerable to food insecurity[53]. Moreover, women and girls traditionally eat last and often less, with men being fed first[54].

Women and girls, especially pregnant and lactating women, are therefore more at risk of under malnutrition or malnutrition, which may have a negative effect on their immune system, leaving them more susceptible to COVID-19[55]. Despite children being globally less affected by COVID-19, children in the Rohingya camps may also be more susceptible due to high levels of undernourishment: one third of Rohingya children aged 1 to 5 years are chronically undernourished[56].

COVID-19 will exacerbate existing gaps in the health system

The health sector is challenged by large caseloads at health facilities and high staff turnover. The 2019 joint Multi-Sector Needs Assessment (MSNA) reported that 80 per cent of Rohingya and host community households have at least one member with an illness serious enough to require medical treatment, with this individual more likely to be a woman or girl[57]. Critical gaps still remain in health services that particularly affect women and girls, namely, comprehensive

emergency obstetric care, newborn care, family planning and contraceptive provision, comprehensive clinical management of rape and other health services for GBV survivors[58].

Gender barriers in accessing health will limit detection and treatment of COVID-19

Women and girls, both from host and Rohingya communities, face limited access to health services. Some of the constraints and issues facing women and girls in accessing health services include safety issues while travelling to health facilities, fear of GBV, the inadequate number of health professionals, long queues at health facilities and lack of confidence in the quality of the health treatment[59]. The restrictions on mobile network in the camps, which have also affected some host communities, prevents them from calling ambulances to bring pregnant women to the hospital in case of emergency deliveries[60].

Transgender populations face barriers in accessing quality health care, especially due to the discrimination they are confronted with[61]. The already limited trust in the health-care system by both Rohingya women and men has deteriorated even further according to a number of surveys conducted with the communities, and rumours persist around COVID-19 patients being killed in health facilities[62]. The increasing fear of infections and the overburdened health facilities may further limit access and demand of women, girls and transgender populations for health services[63].

Gains made in sexual reproductive health may be lost due to COVID-19

Some improvements had been highlighted in 2019. The proportion of refugee women accessing facility-based deliveries has improved from 32 per cent at the start of 2019 to 47 per cent by the end of September 2019[64]. The number of basic emergency obstetric and neonatal care facilities in the camps is up to Sphere guidelines[65]. Contraceptive prevalence rates in the camps have also increased from 32 per cent in 2018 to 35 per cent in 2019[66]. With COVID-19, the gains made in sexual reproductive health may be lost due to these services being deprioritized as resources are diverted to the COVID-19 response, as well as due to increased difficulties for women and adolescent girls in accessing these services.

The Covid-19 Bangladesh Multi-Sectoral Anticipatory Impact and Needs Analysis, conducted in April at national level by the Needs Assessment Working Group, has already seen evidence of this, with 43 per cent of healthcare workers surveyed reporting having heard of pregnant women or mothers dying in their area in the previous week,
and 25 per cent of healthcare workers noting a decrease in the number of women visiting health facilities[67].

COVID-19 will impact the mental health of Rohingya refugees and increase the need for mental health and psychosocial support

Trauma from the targeted violence in Myanmar and the difficult exodus to Bangladesh has left many Rohingya refugees with mental health needs. Conditions in the camps and uncertainty around their future has further negatively impacted the mental health of all refugees[68]. Mental health is generally not well understood by Rohingya communities, with many issues either going unnoticed or believed to be signs of black magic and possession[69]. Lockdown measures may make mental health and psychiatric patients harder to reach and more at risk of abuse from household members.

Consultations with communities, including with women and adolescent girls, showed increased anxiety and stress stemming from the COVID-19 situation[70]. Women, as primary caregivers in the household, may see an even higher impact on their mental health as they will be more exposed to the trauma of the virus. Restrictions in staff and activities may make it harder for Rohingya refugees to access mental health and psychosocial support. Survivors of GBV may be particularly impacted by this.

Gendered barriers in accessing WASH will limit the ability of women, girls and transgender populations to prevent COVID-19

Access to WASH facilities by refugee women and girls has been well documented as highly problematic. Women and girls have highlighted factors such as fear of violence and harassment, lack of adequate lighting and limited privacy as barriers to accessing water points, latrines, bathing and washing facilities. WASH facilities were the most frequently reported area by refugee women and the second most frequently reported area by host community women where they do not feel safe[71].

Women of all ages were more likely to use makeshift spaces in their shelters to bathe compare to men, but this was especially true for older women (87 per cent)[72]. To avoid harassment and waiting in line with unknown men, many women and girls would access WASH facilities at strategic times where men and boys were less likely to be there, such as when they would be engaged in daily work[73]. With lockdown measures, this has become significantly harder as men's movements have been considerably reduced. This will significantly affect the ability of women and girls, especially older women, to protect themselves from COVID-19 through personal and household hygiene.

Menstrual hygiene management (MHM) will be disrupted during COVID-19 pandemic

Gaps in MHM were observed prior to COVID-19, with almost a quarter of households not receiving menstrual hygiene materials regularly enough[74]. Restriction in movements and reduction of services, as well as camp-based livelihood activities in women-friendly spaces shifting from reusable menstrual products to mask production, can limit women's access to menstrual products. Potential harmful and stigmatizing beliefs around menstruation, including believing menstruation to be an illness or linked to black magic and women being regarded as unclean during menstruation, may also put women and adolescent girls at greater risk of violence[75]. Lack of access to menstrual hygiene materials and to safe and discreet disposal or cleaning methods, may limit the ability of female frontline workers and female Rohingya volunteers to work.

Lack of sufficient water and soap will prevent women and girls from protecting themselves and their families from COVID-19 and will significantly add to their time burden

The 2019 MSNA reported that 13 per cent and 17 per cent of host and refugee households respectively did not have enough water for personal hygiene and 35 per cent and 41 per cent did not have enough water for other domestic purposes, including cleaning[76]. Moreover, since many water sources have been established in low lying areas, households living on top of hills face challenges in collecting enough water, especially those with mobility restrictions, such as persons with physical disabilities, elderly persons, or pregnant women[77]. The drought from February to April affecting Teknaf also compounded the difficulties of Rohingya and host communities in accessing water, especially in and around camps 26 and 27.

This may not only limit households' ability to protect themselves from COVID-19, but as women and girls are predominantly responsible for collecting water, this will increase their unpaid care-giving work burden. Anecdotal reports of this already happening in camps have been noted through consultations with Rohingya female volunteers working with UN Women. Crowded water points may also limit women and girls' ability to keep safe social distances, making them more at risk of contracting the disease.

Moreover, when water is scarce, women and girls will use less of it for hygiene purpose, which also puts them at higher risk of infection[78]. Finally, around one third of households reported not having soap, and more than half reported not receiving a sufficient amount of soap for bathing or laundry[79], which in turn will have an impact on households' ability to prevent COVID-19 through proper hygiene practices.

Access to safe shelter can help refugees and host communities protect themselves from COVID-19, but the impact of the virus will make this harder

Having a safe space to live and confine themselves will improve people's ability to protect themselves from COVID-19. However, the lack of space and privacy in the shelters of Rohingya refugees may lead to increasing protection-related risks, such as GBV and child abuse. Moreover, restrictions in services and humanitarian access will have an impact on refugees' ability to improve their shelters, with 81 per cent of households reporting facing an issue with their shelters, such as leaking roof or damaged bamboos[80].

Households with no adult male or with at least one member requiring assistance to complete daily activities were more likely to fail to make needed improvements in their shelters, highlighting that the impact will therefore be higher for households with more vulnerable members (for example, persons with a disability, older persons, pregnant women, chronically ill persons)[81]. Lower or loss of income due to restrictions in place to prevent the spread of COVID-19 will impact host communities' ability to pay rent and make improvements in their shelters.

Although most host communities do own or co-own the land where their shelter is located (85 per cent), one in ten reported feeling at risk of eviction or being evicted[82]. This will disproportionately affect female-headed households and households with no adult male members due to women's unequal access to livelihoods opportunities. As one in ten Rohingya household reported paying rent or money to live in their shelters, especially in Teknaf, similar if not worse impacts are to be expected[83].

The death of male heads of household due to COVID-19 may have a dire impact on female family members, especially widows, both in terms of their ability to pay the rent and make improvements in the shelter, but also in terms of house and land ownership. The current cyclone season and the upcoming monsoon season will be an added challenge on top of these issues.

COVID-19 lockdown measures may impact girls' and boys' access to education

While young girls have more opportunities to go to learning centres or religious schools, adolescent girls and unmarried young women face much greater restrictions on accessing any type of education, due to harmful gendered socioreligious norms, lack of gender-segregated or gender-sensitive learning friendly facilities and real or perceived safety risks[84]. Only 34 per cent of girls

aged 12-18 years were attending learning centres last year, compared to 67 per cent of boys that age[85].

Instead, they are mostly confined at home doing household chores, including collecting water in groups with other girls and women. Some do have the ability to attend women or adolescent safe spaces and engage in home-based learning, although the numbers remain low: only 17 per cent of adolescent girls reported attending home-based learning on a typical day, compared to 36 per cent of adolescent boys, and only 4 per cent reported going to an adolescent friendly space compared to 28 per cent of adolescent boys [86].

Adolescent girls in host communities have much greater access to education compared to their Rohingya counterparts, with 67 per cent of girls aged 12 to 17 years attending formal education programs, outpacing boys of that age by eight percentage points[87]. The lower enrolment rates for boys highlights the fact that many have dropped out of schools to support families through income-generating activities[88].

Cox's Bazar district has high levels of child labour, with 8 per cent of households in host communities reporting at least one child working to earn an income[89]. With learning centres and schools closed to slow the pace of the outbreak, adolescent girls and boys in both Rohingya and host communities are now more at risk of dropping out permanently to help with unpaid care-giving work or to enter the labour force.

Access to Information and Consultations

Women, especially older women and older men, have less access to lifesaving information on COVID-19

A number of barriers hinder Rohingya women and men accessing information, including restriction of movement, a recent mobile network ban and language and literacy limitations. Information, both reliable and fake, is accessed through Facebook, YouTube, WhatsApp and televisions found at tea stalls, and radio stations (Bangladeshi, Burmese and community-based)[90]. Host communities also access information through newspaper and discussions with other community members at tea stalls[91]. COVID-related information has been received through mosques and imams, through NGO workers and via loudspeaker announcements[92].

Women have overall much less information than men, with their access to it highly dependent on men[93]. Many of the sources noted are mostly accessible by men, especially tea stalls and mosques. Consultations with older women have highlighted that their only source of information were male household members, which would therefore leave them uninformed if the men were not inclined to share information[94]. Older men also reported having less access to information[95]. Households with a member living with a disability also have limited access to information[96].

While sharing information through microphones, tom-toms and other means have shown to be effective, such mediums fail to reach those with limited access to public spaces, such as women, older people and persons with disabilities, highlighting the need for more targeted information dissemination strategies.

Restrictions due to COVID-19 will further hinder the access to information for Rohingya refugees, especially women and girls

Overall, both men and women reported having a lack of information on COVID-19. The restrictions in movement and closures of shops and other public spaces are expected to significantly impact people's ability to access information, as noted by the community members themselves[97]. Women-friendly spaces and door-to-door awareness sessions by female Rohingya volunteers have been an important and preferred source of information for women on COVID-19, as highlighted from consultations with Rohingya women themselves[98]. In fact, a majority of women and men reported preferring receiving information in person over any other means of disseminating information[99].

Restrictions on both movements and activities, as well as lack of protective equipment for volunteers, will also reduce women and girls' already limited access to information. Anecdotal reports of female volunteers feeling more reluctant going door-to-door have already been noted[100]. One positive point has been the partial re-establishment of the mobile phone and Internet network in the camps and neighbouring communities since 9 Apri 2020, following the six-month ban introduced by the government, yet the network remains weak and unstable across camps. As women reportedly have less access to mobile phones (63 per cent of men compared to 52 per cent of women in 2017), especially smart phones with Internet access, this may have little impact on their access to information[101].

Lack of consultation with marginalized groups, including women and girls, persons with disabilities and transgender populations will make the COVID-19 response less effective

Accountability and feedback mechanisms in place in the camps are less accessible to women and girls. Complaint boxes exclude them due to literacy and accessibility issues[102]. A number of recent perception surveys conducted with both Rohingya women and men did not report by gender, making it difficult to know what the specific concerns and needs are of women and girls on COVID-19. Restrictions on humanitarian actors in the camps may impact the existing consultations and feedback mechanisms.

Influence of Religious Beliefs and Practices

Not taking religion into account in COVID-19 preparedness and response interventions will decrease its effectiveness, especially for women and girls

Religion is central to the lives of most Rohingya refugees. Religion informs the roles and desired values of women, girls, men and boys. The most important impact on women and girls is the influence of gender on perceptions of honour (*izzot*) and the practice of purdah, and their effect on their mobility and their ability to participate in public spaces. The importance of maintaining purdah may lead to women and girls not being able to access shielding, isolation and treatment facilities if these are not segregated by gender. Consultations with men and women have shown that most would not allow women and girls to go into isolation and treatment with unknown men, with the concept of mixed rooms being unacceptable to everyone[103].

Beliefs based on religion around COVID-19 have given rise to the social stigmatization of women

Religion has also been key to how Rohingya communities understand COVID-19, with many viewing it as a punishment from God[104]. Consultations with Rohingya women and men highlighted

that activities by women judged as "dishonourable", such as failing to observe purdah, was one of the causes of COVID-19[105]. This will give rise to increased policing of women and girls, which in turn will further restrict their mobility and access to services, and will contribute to the escalation of GBV.

Mosques are an important and trusted source of information on COVID-19 for men and boys, but misinformation and lack of social distancing may put them at higher risk of infection

Imams and mosques have been seen as an important source of trusted information on COVID-19 and have played an important role in addressing rumours and misinformation[106]. Religious leaders were found to be the second preferred source of information on COVID-19 for men and women, and the most trusted one according to a survey done by Samaj Kalyan Unnayan Shangstha (SKUS)[107]. Men and women, including older men and women, have reported the importance of prayers to prevent the virus and protect themselves and their families[108].

This initially translated to an increase in religious gatherings as a way to protect themselves, with limited social distancing measures in place[109]. This continues to be the case for some mosques in the camps where more religious leaders need to be effectively engaged in COVID-19 prevention measures and messaging[110]. Therefore, men and boys who access these mosques may be at higher risk of contracting the virus, and in turn of transmitting it to members of their households.

Safety and Protection

COVID-19 will lead to increased levels of gender-based violence

The 2015 Report on Bangladesh Violence Against Women Survey reported that 73 per cent of married women in Bangladesh experienced intimate partner violence in their lifetime, with 50 per cent reporting physical violence[111]. In the camps, while absolute numbers of GBV cases are not shared for protection-related reasons, hundreds of incidents were said to be reported each week at the beginning of the influx, and currently 76 per cent of total reported cases are domestic violence cases[112].

Women in self-organized groups, female volunteers and staff working in camps have faced high levels of harassment, threats and backlash particularly from male community members, *majhis* and religious leaders[113]. GBV is also a key concern for transgender populations. Social stigma and discrimination have made them less visible, and they are therefore often forgotten in mainstream GBV prevention and response activities. The lockdown may lead to transgender persons having to stay in hostile environments, or with unsupportive or bullying families[114].

Across the world, the pandemic has been accompanied with a worrisome rise in violence against women and girls, especially domestic and intimate partner violence. Media reports have already captured this increase in Bangladesh nationally, with numerous reports of perpetrators taking advantage of the lockdown and pandemic, which has limited both reports of GBV and the legal discourse on abuse and assault[115]. Consultations with Rohingya women and adolescent girls have reported increases in household tensions and GBV in the camps[116].

Female volunteers, on which a lot of the COVID-19 response will rely on once humanitarian actors are no longer able to access camps, may face increased harassment and violence, limiting their ability to do their work and reach vulnerable women and girls. Finally, the increasing reliance on

volunteers to deliver activities and the reduction of humanitarian actors may lead to a sharp increase in sexual exploitation and abuse, with less avenues for survivors to report[117].

Restrictions to prevent the spread of COVID-19 will limit access of GBV survivors to lifesaving support

The MSNA showed that only 15 per cent of Rohingya respondents knew all four key GBV resources (those relating to health, justice and the legal realm, the psychosocial realm and security), and women were consistently less able than men to name resources apart from *majhis*[118]. More host community members knew which resources to access, although again women overall had less information[119]. Women and girls' safe spaces are crucial entry points for reporting GBV and accessing services: these are known to women, who feel more at ease receiving support there compared to health clinics, and the security and privacy they offer have made them acceptable to men[120]. However, older women, women and girls with disabilities and adolescent girls face more barriers to access these, in turn making it more difficult for GBV actors to reach and support them[121].

Receiving justice for GBV survivors is often limited to community mediation for the Rohingya, which are governed by male leaders and are rarely survivor-centred or gender-responsive[122]. Women reported being unlikely to seek legal help out of fear of unjust verdicts, including being forced to marry the perpetrator[123]. Transgender persons are also at risk of abuse and harassment by the authorities, making them less likely to report GBV cases[124].

This will exacerbate during the COVID-19 prevention and response, with perpetrators more likely to act knowing that impunity levels are higher. Limiting access to GBV services is taking place due to restrictions in movement, a fear of infections, reductions in activities and staff and uncertainties caused by the closures of women safe spaces. Therefore, GBV survivors are less likely to be able to access support or report cases during the COVID-19 pandemic.

COVID-19 has increased violence against children

Children and adolescents face a number of risks in both the camps and host communities, with age, gender, disability and other aspects of identity being equated with additional vulnerabilities. Threats that both caregivers and adolescents are concerned about for children and adolescents include a child going missing, kidnapping and trafficking, physical illness, road accidents and verbal harassment[125]. Girls are regarded as primarily at risk of kidnapping/trafficking, sexual harassment and early/forced marriage, boys at risk of kidnapping, road accidents and going missing, while children with disabilities at risk of physical illness, road accidents and lack of safety in their homes[126].

While reported rates of child/forced marriage remain low (5-10 per cent of households), actual rates are expected to be much higher as almost one third of caregivers believed it was acceptable to arrange their daughter's marriage to keep her safe[127]. Early/forced marriage particularly affects girls, who are married to older men as a way to protect them or to reduce the household economic burden[128]. In fact, 41 per cent of adolescent girls (aged 15 to 20) reported being married, compared to 20 per cent of adolescent boys of the same age[129]. Violence as a means to discipline children is widely regarded as acceptable: in a joint child protection subsector assessment, 94 per cent of

caregivers and 85 per cent of adolescents reported that parents could discipline children by resort to violence[130].

COVID-19 will have a negative impact on child protection efforts

Closure of temporary learning centres, schools and the partial closure of child friendly centres (except for provision of individual case management and counselling services) and an increase of household tensions are leaving children and adolescents at greater risk of abuse, neglect and violence. Early/forced marriage and trafficking may increase as negative coping mechanisms. The national impact assessment has already reported a 40 per cent increase in calls to child helplines[131]. Restrictions in movement, lower levels of decision-making power and reductions in services and staff will limit the ability of child survivors of violence to report issues or to seek support.

COVID-19 has already damaged the social cohesion between the host and Rohingya communities

Tensions between host communities and Rohingya communities, stemming from the impact the influx has had on the livelihoods of host communities and their well-being, have been a source of risk for women, girls, men and boys in both the host and Rohingya communities. Reports from refugees have shown the "rapidly deteriorating security dynamics within the camps between Rohingya and host communities", stemming from fears around COVID-19[132]. Tensions are also growing due to the economic impact of COVID-19 and the host communities feeling excluded from the assistance available to them compared that extended to the Rohingya communities[133].

Further intra-communal tensions and insecurity dynamics may also arise as the Rohingya refugees are being blamed for the spread of the virus due to the unhygienic and overcrowded conditions in the camps[134]. This has led to an increase in hate speech, racism and social stigma, which is already evident in local media reporting, and in the rise in crime and attacks against the Rohingya by the local host population.

Disaster preparedness and response will be hampered by COVID-19, and this will impact the most vulnerable populations

The conditions in the camps, with their high density and overcrowding, the temporary shelters, lack of cyclone shelters and limited options for evacuation, have made Rohingya communities at particular risk of disasters. The strain on services, infrastructures and the environment from the influx of refugees has also increased the vulnerability of host communities to disasters. The exposure of these communities to disasters would exacerbate already existing needs and vulnerabilities, especially for the most marginalized, including women and girls, persons with disabilities, elder persons and children[135]. The first cyclone season, which runs from April to May, has already started and the monsoon season, from June to September, is approaching.

COVID-19 has put additional stress on the disaster preparedness and response, as any activities will need to limit communities' exposure to the virus while simultaneously protecting those infected and those on lifesaving treatment[136]. Restrictions on humanitarian actors' access to the camps significantly increase the need to place communities at the forefront of the response, including through strong awareness-raising and information dissemination and ensuring a community-based approach to emergency preparedness and response[137]. As women and girls have less access to information, decision-making, leadership and governance structures in both camps

and host communities, this limits their ability to participate in such activities and accessing early warning messages in time, which can significantly decrease their effectiveness and lead to the disproportionate impact of disasters on women.

Recommendations

For all sectors

- Collect and analyse sex, age and diversity disaggregated data on infection rates and prevention and response activities, and regularly conduct gender analysis to understand the differentiated impact of COVID-19 on women, girls, men, boys and other vulnerable populations.
- Develop and monitor specific gender indicators in all sectors' preparedness and response plans to assess the impact, trends and reach of the interventions.
- Ensure women and girls are consulted and take on meaningful decision-making and leadership roles in the planning and implementation of COVID-19 preparedness and response activities.
- Engage women volunteers, women leaders and women's network to reach out to women and girls.
- Design all prevention and response activities and messages to mitigate the additional time burden of women and girls.
- Ensure all women frontline workers have sufficient information, services and tools to protect themselves and their families.
- Prepare for, mitigate and respond to a potential backlash against women based on social and religious norms.
- Ensure an adequate number of female volunteers and frontline workers to share information with and provide services to women and girls in a socio-culturally appropriate way

For specific sectors and working groups

CWC

- Ensure information is accessible to all, including those harder to reach, such as women and girls, older persons and persons with disabilities.
- Develop targeted informational and awareness messages based on community consultations about COVID-19 for women and girls and disseminate them through channels that are safe and accessible for women, including door-to-door visits by female volunteers.
- All assessment and perception surveys need to be conducted with a gender lens and capture the different needs and capacities of women, girls, men and boys, as well as the perceptions of diverse groups.
- Engage religious leaders who are more favourable to women's empowerment in consultations and awareness-raising with communities on preventing GBV, promoting more gender-equal household dynamics and reducing social stigma around women violating purdah rules.
- Continue to track rumours and address those that affect women and girls by developing targeted messages that female volunteers can use when engaging women and girls.

Emergency Preparedness

- Engage communities in cyclone preparedness activities, ensuring that women are able to effectively participate.
- Ensure all information around cyclone preparedness reaches women and girls through targeted messages and dissemination channels.

Education

- Ensure all home-based educational activities target adolescent girls.
- Introduce measures as part of the education sector strategy to reduce impediments -- such as the increased caregiving that adolescent girls are having to give as a result of COVID-19, which is an additional burden on their time -- so that they can access education.

Health

- Maintain all critical services and supplies, as defined by the Minimum Initial Services Package for sexual reproductive health services. Adapt service provision to the lockdown measures and provide information to women and adolescent girls on how to continue accessing these.
- Ensure women can play an equal and effective role in the leadership and management of quarantine, isolation and treatment facilities.
- Ensure the presence of female staff in all health facilities, especially in quarantine, isolation and treatment facilities.
- Maintain Mental Health and Psychosocial Support Services (MHPSS), adapt service provision to the lockdown measures and provide information to women, girls, men and boys on how to continue accessing these.
- Provide MHPSS to frontline workers who are more exposed to the trauma surrounding the virus.
- Work with women leaders, community leaders and religious leaders to visit, assess and monitor health clinics so they can respond to rumours and negative perceptions of health services, and encourage women and men to access these for COVID-19 and non-COVID-19 related needs.

Food Security

- Ensure all livelihoods and cash-based interventions developed to support the Rohingya and host communities are developed with a gender-lens, target women and adolescent girls and mitigate GBV.
- Continue to support women in both host and Rohingya communities to engage in homestead gardening.
- Increase the engagement of women and adolescent girls in the production of masks as an income-generating opportunity and a way to include them in prevention activities.

Nutrition

- Ensure older women and those with underlying medical conditions, pregnant and lactating women have access to an adequate and nutritious diet.

- Ensure children, especially girls, have access to an adequate and nutritious diet, including dietary complements when needed.

Protection

- Do not deprioritize services and staffing for lifesaving GBV response and prevention, and continue to advocate for and negotiate their access.
- Adapt GBV services and referral pathways as necessary to address new restrictions in movements and access to services, and to ensure sustained service provision to GBV survivors.
- Ensure women, girls, men and boys have updated information on available GBV services regarding any changes that have occurred and on how to access these.
- Train all first responders and frontline workers on dealing with GBV disclosures and referrals of GBV cases.
- Adapt child protection as necessary to address new restrictions in the camps, and continue resourcing and plan for an expected increase in the need for services, especially around trafficking, child marriage and abuse.
- Ensure women, girls, men and boys have information on the child protection services available and how to access these, including through targeted and child-friendly information for children.
- Ensure all staff and volunteers engaged in the COVID-19 response and wider humanitarian response are provided refresher briefings on preventing sexual exploitation and abuse.

SMSD

- Include gender officers, gender volunteers, women leaders and women's networks in all preparedness and response activities for COVID-19.
- Ensure women are engaged and gender considerations are taken into account in the planning and managing of isolation and treatment facilities as per guidance and checklists developed based on community consultations.
- Ensure gender considerations are taken into account for safe and dignified burial management, in line with findings on this based on consultations with the community.

Shelter/NFI

- Ensure the most vulnerable households, including female-headed households, still have access to materials and support to make shelter improvements and to prepare for the cyclone season.
- Provide culturally and gender appropriate NFIs, including for those in isolation and quarantine facilities.
- Provide women and men in quarantine and isolation facilities required NFIs to allow them to continue religious activities, especially during Ramadan.

WASH

- Prioritize menstrual hygiene management, ensure women and girls have ongoing access to appropriate products and have safe and dignified ways to clean and/or dispose of them, including in treatment, isolation and quarantine facilities.

- Ensure female frontline workers have access to MHM products and ways to dispose/clean these.
- Ensure sufficient quantities of soap for bathing and laundry are distributed to Rohingya households.
- Design targeted interventions for older women, who largely do not access WASH facilities, to ensure they can maintain their personal hygiene to protect themselves from COVID-19 based on having consultations with them.

End Notes and Bibliography

[1] WHO *et al.*, 2020.
[2] WHO *et al.*, 2020.
[3] United Nations Development Programme (UNDP), 2018.
[4] WHO *et al.*, 2020.
[5] Office of the United Nations High Commissioner for Refugees (UNHCR) as of 31 March 2020; Inter-Sector Coordination Group (ISCG), 2019d.
[6] UNHCR, 2020.
[7] See Basic Needs section.
[8] UNHCR, 2020; ISCG, 2019d.
[9] ISCG, 2019d. Ibid., 2019e. Innovations for Poverty Action (IPA), 2019.
[10] UNHCR as of March 31st 2020: https://data2.unhcr.org/en/situations/myanmar_refugees
[11] As defined by the 2020 Joint Response Plan. ISCG, 2019c.
[12] International Organization for Migration (IOM) and UN Women., 2020.
[13] IOM and UN Women, 2020.
[14] IOM and ACAPS, 2020.
[15] CARE *et al.*, 2020.
[16] Oxfam, 2018.
[17] CARE *et al.*, 2020.
[18] Ibid., 2020.
[19] REACH and UNICEF, 2020.
[20] Toma *et al.*, 2018.
[21] UN Women, 2020.
[22] IOM and ACAPS, 2020c.
[23] UN Women, 2020.
[24] Toma *et al.*, 2018. IOM and UN Women, 2020.
[25] CARE *et al.*, 2020.
[26] Ibid., 2020.
[27] Toma *et al.*, 2018. IOM and UN Women., 2020.
[28] CARE *et al.*, 2020. Toma *et al.*, 2018.
[29] ISCG, 2019d; Ibid., 2019e.
[30] Oxfam, 2019.
[31] CARE *et al.*, 2020.
[32] Ibid., 2020.
[33] REACH and UNICEF, 2020.
[34] Oxfam, 2019. Toma *et al.*, 2018.
[35] Protection Sector, 2018.
[36] CARE *et al.*, 2020.
[37] Gender in Humanitarian Action Working Group (GiHA WG) for the Rohingya Refugee crisis response in Cox's Bazar (GiHA WG), 2019.
[38] IOM and UN Women, 2020. CARE *et al.*, 2020.
[39] Oxfam, 2019.
[40] Gender in Humanitarian Action Working Group (GiHA WG), 2019. Oxfam, 2019.
[41] GiHA WG, 2019.
[42] World Food Programme (WFP), 2019.
[43] CARE *et al.*, 2020.
[44] ISCG, 2019b.
[45] REACH and UNICEF, 2020.
[46] ISCG, 2019b.
[47] Ibid., 2019e.
[48] UNDP, 2018.
[49] Bandhu, 2020.
[50] UN Women, 2020.
[51] CARE *et al.* 2020.

[52] WFP, 2019.
[53] ISCG, 2019b.
[54] Toma *et al.*, 2018.
[55] CARE, 2020.
[56] ISCG, 2019b.
[57] Ibid., 2019b; 2019c.
[58] Ibid., 2020a.
[59] CARE *et al.,* 2020.
[60] Ibid*.,* 2020.
[61] Bandhu, 2020.
[62] ACAPS, 2020. IOM and ACAPS, 2020b. Consultations with Rohingya women and girls by UN Women, April 2020.
[63] Bandhu, 2020.
[64] ISCG, 2020a.
[65] Health Sector, 2019.
[66] United Nations Population Fund (UNFPA), 2019.
[67] Needs Assessment Working Group (NAWG), 2020.
[68] UNHCR, 2018. Médecins Sans Frontières (MSF), 2019.
[69] MSF, 2019.
[70] Consultations with women and adolescent girls by UN Women, April 2020.
[71] ISCG, 2019d; Ibid., 2019e.
[72] REACH and UNICEF, 2019b.
[73] IOM and ACAPS, 2020e.
[74] REACH and UNICEF, 2019d.
[75] Ibid., 2019d.
[76] ISCG, 2019d; Ibid., 2019e.
[77] Bangladesh Red Crescent Society (BRCS), 2019.
[78] REACH and UNICEF, 2019c.
[79] Ibid., 2019a.
[80] ISCG, 2019d.
[81] Ibid., 2019b.
[82] Ibid., 2019e.
[83] Ibid., 2019b.
[84] CARE *et al.*, 2020. Oxfam, 2019.
[85] ISCG, 2019d.
[86] CARE *et al.*, 2020. REACH and UNICEF, 2020.
[87] ISCG, 2019e.
[88] Gender and Adolescence: Global Evidence (GAGE), 2019.
[89] GAGE, 2019. ISCG, 2019e.
[90] BBC Media Action and Translators Without Borders (TWB), 2020a. What Matters #33; IOM & ACAPS, 2020a.
[91] BBC Media Action and TWB, 2020a.
[92] IOM and ACAPS, 2020a.
[93] BBC Media Action and TWB, 2020a.
[94] Ibid., 2020b.
[95] Ibid., 2020b.
[96] IOM and ACAPS, 2020e.
[97] BBC Media Action and TWB, 2020b.
[98] GiHA WG, 2020a. UN Women, 2020.
[99] Samaj Kalyan Unnayan Shangstha (SKUS), 2020.
[100] GiHA WG, 2020b.
[101] Internews, 2017. Karin *et al.*, 2020.
[102] Oxfam, 2019.
[103] IOM and ACAPS, 2020c.
[104] BBC Media Action and TWB, 2020b.
[105] IOM and ACAPS, 2020d.
[106] BBC Media Action and TWB, 2020b; ACAPS and IOM, 2020a; Ibid., 2020b.

[107] SKUS, 2020.
[108] BBC Media Action and TWB, 2020a; Ibid., 2020b.
[109] IOM and ACAPS, 2020d.
[110] Ibid., 2020d.
[111] Bangladesh Bureau of Statistics (BBS), 2017.
[112] ISCG, 2018. Ibid., 2020a.
[113] Ibid., 2019a.
[114] Bandhu, 2020.
[115] Ibid., 2020.
[116] Consultations with Rohingya Volunteers working with UN Women. UN Women, 2020.
[117] Protection from Sexual Exploitation and Abuse (PSEA) Network, 2020.
[118] ISCG, 2019d.
[119] Ibid., 2019e.
[120] Worker Rights Consortium (WRC), 2019.
[121] WRC, 2019.
[122] Oxfam 2020.
[123] Ibid., 2020.
[124] Bandhu, 2020.
[125] REACH and UNICEF, 2020.
[126] Ibid., 2020.
[127] ISCG, 2019d. REACH and UNICEF, 2020.
[128] ISCG, 2020a.
[129] REACH and UNICEF, 2020.
[130] Ibid., 2020.
[131] Needs Assessment Working Group (NAWG), 2020.
[132] IOM and ACAPS, 2020b.
[133] Ibid., 2020e.
[134] Ibid., 2020b
[135] Protection Sector, 2019.
[136] ISCG, 2020b.
[137] Protection Sector, 2019.

BIBLIOGRAPHY

ACAPS, 2020. *Rohingya Response: Health Behaviours and COVID-19*. https://www.acaps.org/sites/acaps/files/products/files/20200403_acaps_rohingya_response_health_behaviours_COVID_19.pdf

Bandhu Social Welfare Society (Bandhu), 2020. *A Call for Joining Hands: A Message to the Gender Diverse and Hijra Community in Response to COVID-19*.

Bangladesh Bureau of Statistics (BBS), 2015. *Report on Bangladesh Violence Against Women Survey*.

Bangladesh Red Crescent Society (BRCS), 2019. *Perspectives and Priorities from Guest and Host Communities in Cox's Bazar*.

BBC Media Action and Translators Without Borders (TWB), 2020a. *COVID 19: Perception of Host and Rohingya Community*. What Matters: Humanitarian Feedback Bulletin on Rohingya Response Issue 33. https://app.box.com/s/ce8zycs0r8fgfxp45r6f93sx51z2l6va

_____, 2020b. *COVID-19: Older Rohingya community*. What Matters: Humanitarian Feedback Bulletin on Rohingya Response Issue 34. https://app.box.com/s/539lre83v137blggbt88b5w8l8l484m0

_____, 2020c. *COVID-19: Rumours in the camps*. What Matters: Humanitarian Feedback Bulletin on Rohingya Response Issue 35. https://app.box.com/s/2gfphrsyvxret1qnm949ku73quxopwqv

CARE, Office of the United Nations High Commissioner for Refugees (UNHCR) and ActionAid Bangladesh, 2020. *An Analysis of Gender and Intersectionality in Rohingya Refugees and Host Communities in Cox's Bazar, Bangladesh*.

CARE, 2020. *Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings*.

Gender and Adolescence: Global Evidence (GAGE), 2019. *The lives they lead: Exploring the capabilities of Bangladeshi and Rohingya adolescents in Cox's Bazar, Bangladesh*. https://www.gage.odi.org/wp-content/uploads/2019/12/GAGE-Rohingya-brief_WEB-1.pdf

Gender in Humanitarian Action Working Group (GiHA WG), 2019. *Summary Analysis of Consultations with Women on Elections*. https://www.humanitarianresponse.info/en/operations/bangladesh/document/summary-analysis-women-leadership-and-community-representation-july

_____, 2020a. *Minutes of the GiHA WG Meeting on 30 March 3* 2020. https://www.humanitarianresponse.info/en/operations/bangladesh/document/cxb-giha-wg-meeting-30-march-2020

_____, 2020b. *Minutes of the GiHA WG Meeting on April 13th, 2020.* https://www.humanitarianresponse.info/en/operations/bangladesh/document/cxb-giha-wg-meeting-13-april-2020

Health Sector, 2019. *Health Bulletin # 11 - November 2019.* https://www.humanitarianresponse.info/en/operations/bangladesh/document/health-sector-bulletin-no5

Innovation Poverty Action (IPA), 2019. *The Impact of Large-Scale Forced Displacement on Rohingya Refugees and Host Communities in Cox's Bazar, Bangladesh*. https://www.poverty-action.org/study/impact-large-scale-forced-displacement-rohingya-refugees-and-host-communities-cox%E2%80%99s-bazar

International Organization for Migration (IOM) and ACAPS, 2020a. *Overview of Rohingya Perceptions*. COVID-19 Explained, edition #1. https://reliefweb.int/report/bangladesh/covid-19-explained-overview-rohingya-perceptions-edition-1-26th-march-2020

_____, 2020b. *Essentially Abandoned: Essential Service Restrictions Go into Effect.* COVID-19 Explained, edition #2. https://reliefweb.int/report/bangladesh/covid-19-explained-essentially-abandoned-essential-service-restrictions-go-effect

_____, 2020c. *No Isolation without Consultation*. COVID-19 Explained, edition #3. https://reliefweb.int/report/bangladesh/covid-19-explained-no-isolation-without-consultation-edition-3-9-april-2020

_____, 2020d. *The Spaces between Allah and Science*. COVID-19 Explained, edition #4.

_____, 2020e. *Different and Unequal: How COVID-19 affects Different Sex, Age, Ability and Ethnic Groups Differently.* COVID-19 Explained, edition #5.

IOM and UN Women, 2020. *Honour in Transition: Changing gender norms within the Rohingya camps*.

Internews, 2017. *Information Needs Assessment Cox's Bazar - Bangladesh*. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/assessments/internews_coxs_bazar_publication_web.pdf

Inter-Sector Coordination Group (ISCG), 2018. *Joint Response Plan, Rohingya Humanitarian Crisis.*

_____, 2019a. *Gender Reflections: Two Years of the Rohingya Refugee Response*. https://www.humanitarianresponse.info/en/operations/bangladesh/document/gender-reflections-two-years-rohingya-refugee-response-september-2019

_____, 2019b. *Joint Multi-Sector Needs Assessment Final Report: Rohingya Refugees*. https://reliefweb.int/report/bangladesh/joint-multi-sector-needs-assessment-j-msna-rohingya-refugees-september-2019

_____, 2019c. *Joint Multi-Sector Needs Assessment Final Report: Host Communities in Teknaf and Ukhiya Upazilas*. https://reliefweb.int/report/bangladesh/joint-multi-sector-needs-assessment-j-msna-host-communities-teknaf-and-ukhiya

_____, 2019d. *Joint Multi-Sector Needs Assessment Factsheet: Rohingya Refugees*. https://www.humanitarianresponse.info/en/operations/bangladesh/document/coxs-bazar-joint-multi-sector-needs-assessment-msna-fact-sheet

_____, 2019e. *Joint Multi-Sector Needs Assessment Factsheet: Host Communities in Teknaf and Ukhiya Upazilas*. https://www.humanitarianresponse.info/en/operations/bangladesh/document/coxs-bazar-joint-multi-sector-needs-assessment-msna-fact-sheet

_____, 2020a. *Joint Response Plan, Rohingya Humanitarian Crisis*. https://reliefweb.int/report/bangladesh/2020-joint-response-plan-rohingya-humanitarian-crisis-january-december-2020

_____, 2020b. *Cyclone Emergency Preparedness Update*. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/cyclone_emergency_preparedness_update_-_march_2020.pdf

_____, 2020c. *Situational Report February 2020*. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/final_iscg_sitrep_-_february_2020.pdf

Karin, S., Chowdhury, A. and Shamim, I., 2020. *Status of Rohingya Refugees in Bangladesh: A Comparative Study with Emphasis on Aspects of Women and Girls in Camps of Kutupalong, Cox's Bazar, Bangladesh.*

Médecins Sans Frontères (MSF), 2019. *Rohingya Refugee Crisis: Unseen Wounds Need to Heal*. https://www.msf.org/rohingya-refugees-bangladesh-need-more-mental-healthcare

Needs Assessment Working Group (NAWG) Bangladesh, 2020. *COVID 19: Bangladesh Multi Sectoral Anticipatory Impact Analysis and Needs Assessment.*

https://www.humanitarianresponse.info/en/operations/bangladesh/assessment/20200325-COVID19nawg-sitrep-and-anticipatory-impact-updates01

Oxfam, 2018. *Rapid Care Analysis in a Rapid-Onset Emergency: Cox's Bazar, Bangladesh.* https://policy-practice.oxfam.org.uk/publications/rapid-care-analysis-in-a-rapid-onset-emergency-coxs-bazar-bangladesh-620499

_____, 2019. *Him-mot (Courage): Rohingya women as transformative leaders for women's rights in Bangladesh. (Internal document).*

_____, 2020. *Voices Rising: Rohingya Women's Priorities and Leadership in Myanmar and Bangladesh.* https://policy-practice.oxfam.org.uk/publications/voices-rising-rohingya-womens-priorities-and-leadership-in-myanmar-and-banglade-620951

Protection Sector, 2018. *Protection Considerations of the Majhi System*. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/protection_considerations_on_the_mahji_system_pswg_fv_june_2018.pdf

Protection Sector and GiHA WG, 2019. *Rohingya Refugee Response: Sector Cyclone Preparedness* and *Response Plan.*

Protection from Sexual Exploitation and Abuse (PSEA) Network, 2020. *COVID-19 Tip Sheet*. https://www.humanitarianresponse.info/en/node/231458

REACH and UNHCR, 2019. *Multi-Sector Needs Assessment II All Camps Ukhiya/Teknaf, Cox's Bazar, Bangladesh July 2018 and January 2019 comparison*. https://data2.unhcr.org/en/documents/download/68613

_____, 2019a. *Hygiene Item Assessment – Overall Response Level.* https://reliefweb.int/report/bangladesh/hygiene-item-assessment-july-2019-overall-response-level

_____, 2019b. *Water, Sanitation and Hygiene (WASH) Household Monsoon Season Follow-up Assessment.* https://www.humanitarianresponse.info/en/operations/bangladesh/document/reach-latest-updates

_____, 2019c. *Water, Sanitation and Hygiene Qualitative Assessment: Findings on Water Needs.* https://www.humanitarianresponse.info/en/operations/bangladesh/document/reach-latest-updates

_____, 2019d. *Water, Sanitation and Hygiene Qualitative Assessment: Findings on Menstrual Hygiene Management Needs.* https://www.humanitarianresponse.info/en/operations/bangladesh/document/reach-latest-updates

_____, 2020. *Key findings from quantitative and qualitative data collection: Joint Child Protection Sub-Sector (CPSS) Assessment.*

Samaj Kalyan Unnayan Shangstha (SKUS), 2020. *Coronavirus (COVID-19) Messaging Rapid Camp Survey - Preliminary findings.*

Toma, et al., 2018. *Rohingya Refugee Response Gender Analysis: Recognizing and responding to gender inequalities.* https://policy-practice.oxfam.org.uk/publications/rohingya-refugee-response-gender-analysis-recognizing-and-responding-to-gender-620528

United Nations Development Programme, 2018. *Impacts of the Rohingya Refugee Influx on Host Communities.* https://reliefweb.int/sites/reliefweb.int/files/resources/Impacts%20of%20the%20Rohingya%20Refugee%20Influx%20on%20Host%20Communities.pdf

UNHCR, 2018. *Culture, Context and Mental Health of Rohingya Refugees*. https://www.unhcr.org/5bbc6f014.pdf

_____, March 2020. *Joint Government of Bangladesh - UNHCR Population Factsheet (as of March 15, 2020).* https://data2.unhcr.org/en/documents/download/74676

UN Women, 2020. *Rohingya Women Speak Up on COVID-19: Concerns, Demands and Solutions.* https://reliefweb.int/sites/reliefweb.int/files/resources/rohingya_women_speak_up_on_covid-19_in_cxb_un_women_28_april_2020.pdf

Women's Refugee Commission (WRC), 2019. *"We Need to Write Our Own Names": Gender Equality and Women's Empowerment in the Rohingya Humanitarian Response in Cox's Bazar*. https://www.womensrefugeecommission.org/research-resources/we-need-to-write-our-own-names-gender-equality-and-women-s-empowerment-in-the-rohingya-humanitarian-response-in-cox-s-bazar/

World Food Programme, 2019. *Refugee Influx Emergency Vulnerability Assessment (REVA)*. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/2019/06/190618-WFP---REVA-II_0.pdf

WHO and Health Sector, 2020. *Coronavirus disease 2019 (COVID-19): As of 4 May 2020*.