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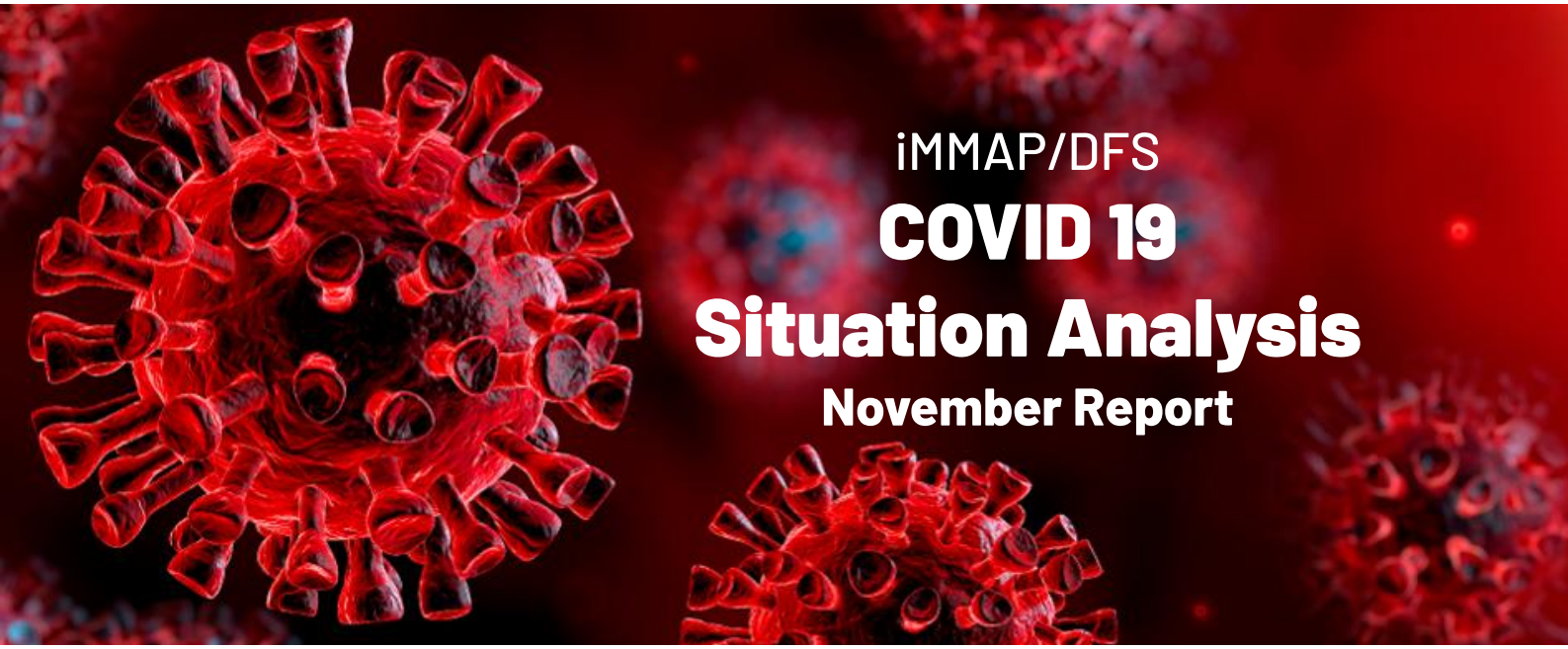


iMMAP/DFS

COVID 19 Situation Analysis

November Report

Period: October 23 - November 30

BANGLADESH

Crisis type: Epidemic

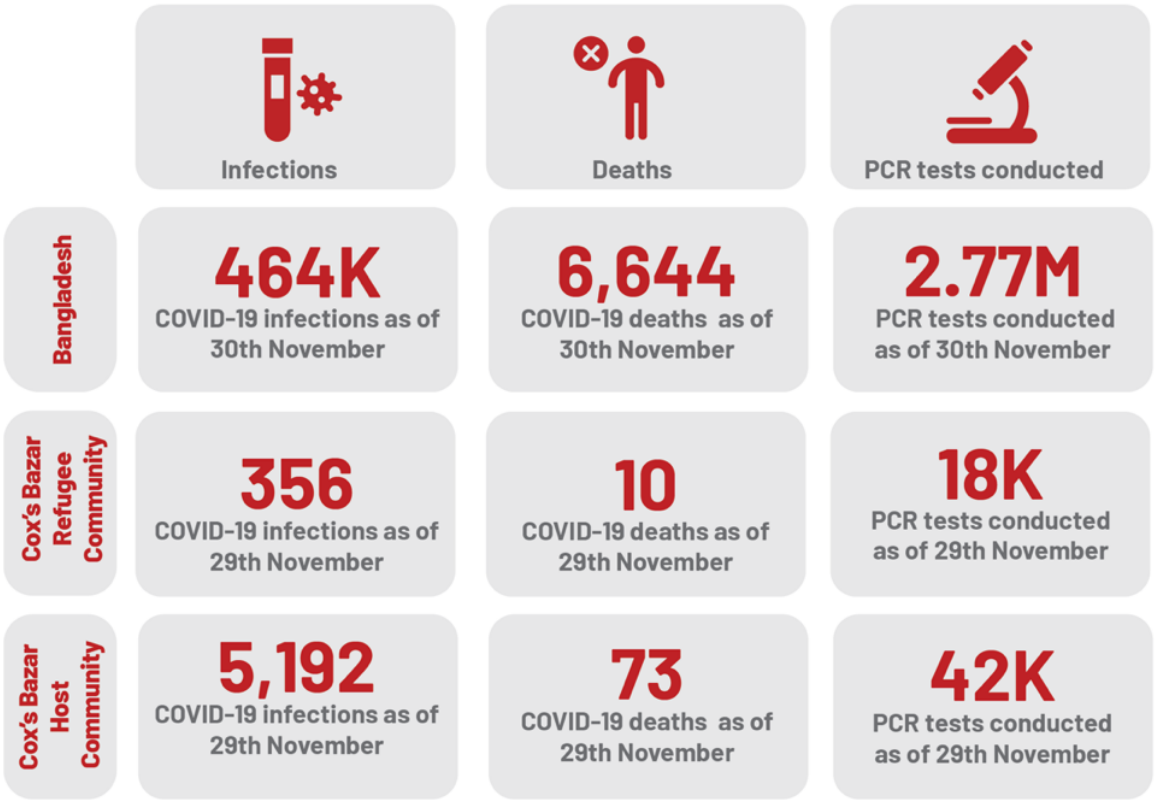
The outbreak of disease caused by the virus known as Severe Acute Respiratory Syndrome (SARS-CoV-2) or COVID-19 started in China in December 2019. The virus quickly spread across the world, with the WHO Director-General declaring it as a pandemic on 11 March 2020.

The virus's impact has been felt most acutely by countries facing humanitarian crises due to conflict and natural disasters. As humanitarian access to vulnerable communities has been restricted to basic movements only, monitoring and assessments have been interrupted.

To overcome these constraints and provide the wider humanitarian community with timely and comprehensive information on the spread of the COVID-19 pandemic, iMMAP initiated the COVID-19 Situational Analysis project *with the support of the USAID Bureau of Humanitarian Assistance (USAID BHA), aiming to provide solutions to the growing global needs for assessment and analysis among humanitarian stakeholders.*

Executive Summary / Highlights

Figure 1: COVID-19 data summary for Bangladesh



COVID-19 infection rates across Bangladesh are relatively stable and well below the peak reached in July/August; testing is also continuing to increase with approximately 19% more tests conducted in November compared to the previous month. Most national COVID-19 containment measures have been rescinded, but public health measures such as wearing masks are still in place, and schools remain closed. In Cox's Bazar, COVID-19 infection rates have dropped significantly, but stringent protocols to prevent the virus's spread remain for humanitarian actors working in the camps.

- An increased humanitarian footprint in the camps has enabled a broader approach to provide COVID-19 information, including community consultation and awareness sessions.
- The recent J-MSNA highlights that the vast majority of respondents reported households resorting to negative coping mechanisms, reflecting the loss of livelihoods, loss of income, and increased food insecurity.
- The security situation has deteriorated in some of the camps, even causing displacement. An increase in protection issues is still being reported, with children amongst those most affected. Major concerns include rising levels of child labor, child marriage, and children going missing.
- Schools remain closed. Access to distance learning remains challenging for refugee children and children from the host community's poorer families.

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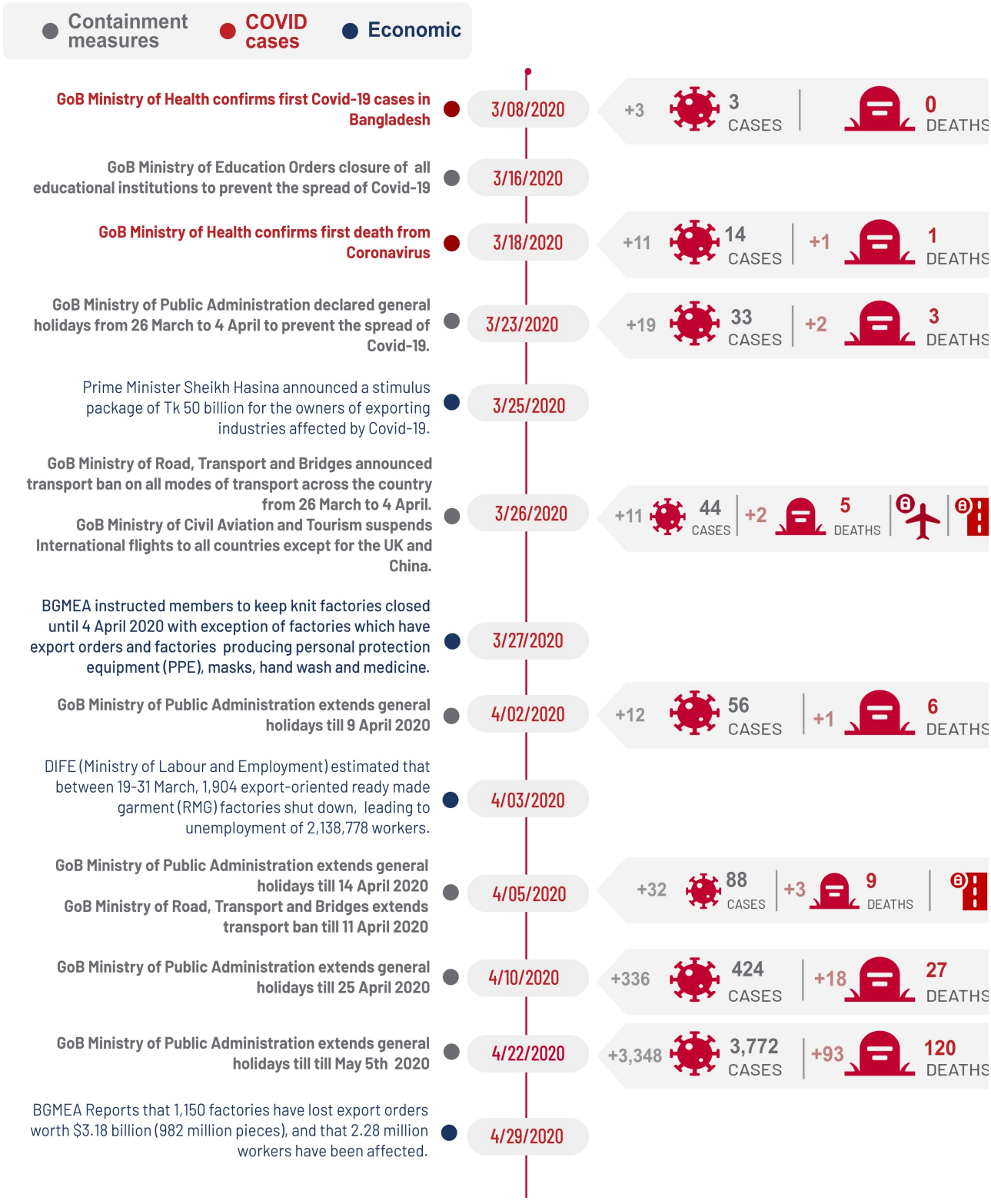
Figure 2: Timeline of Major Events



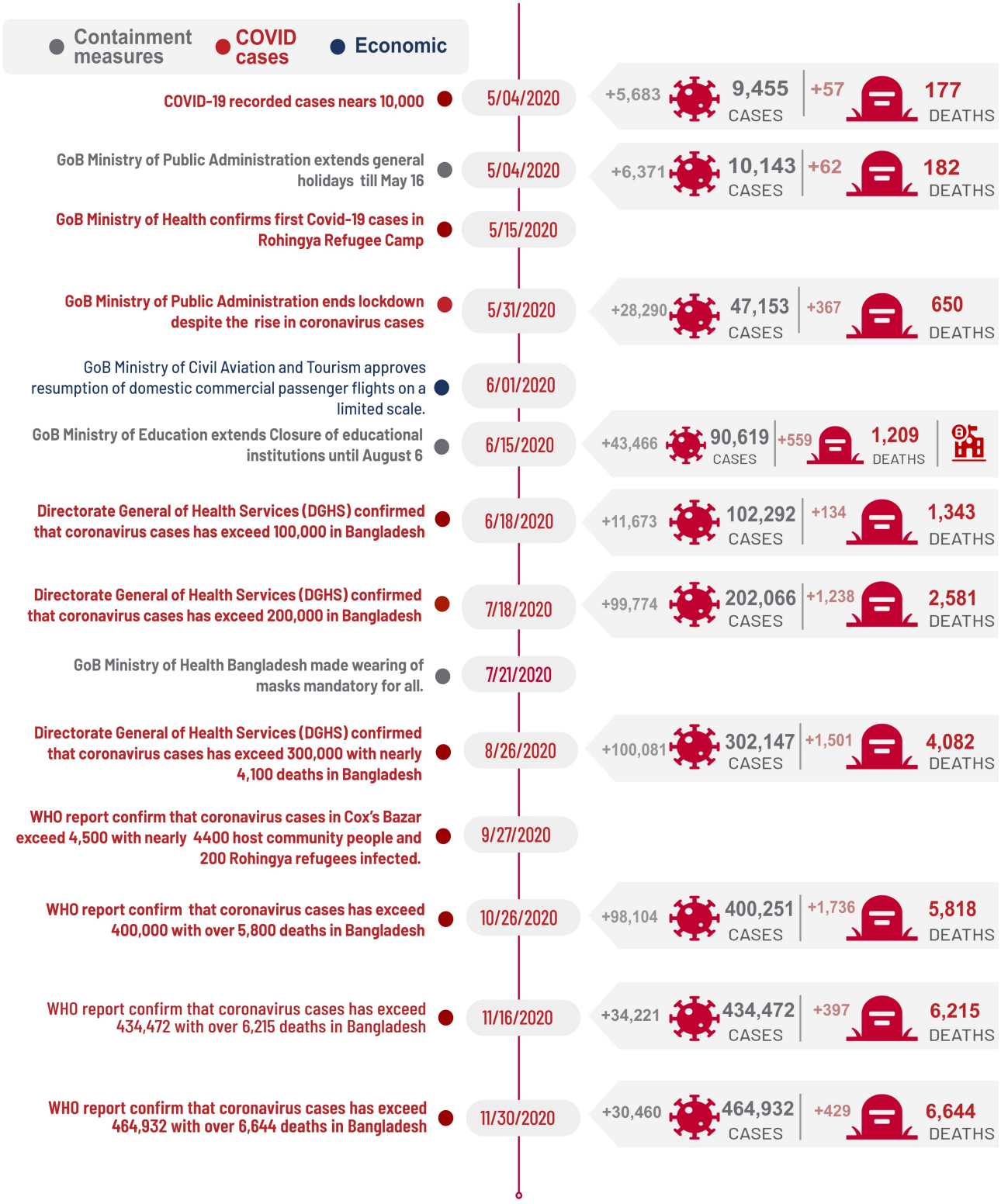
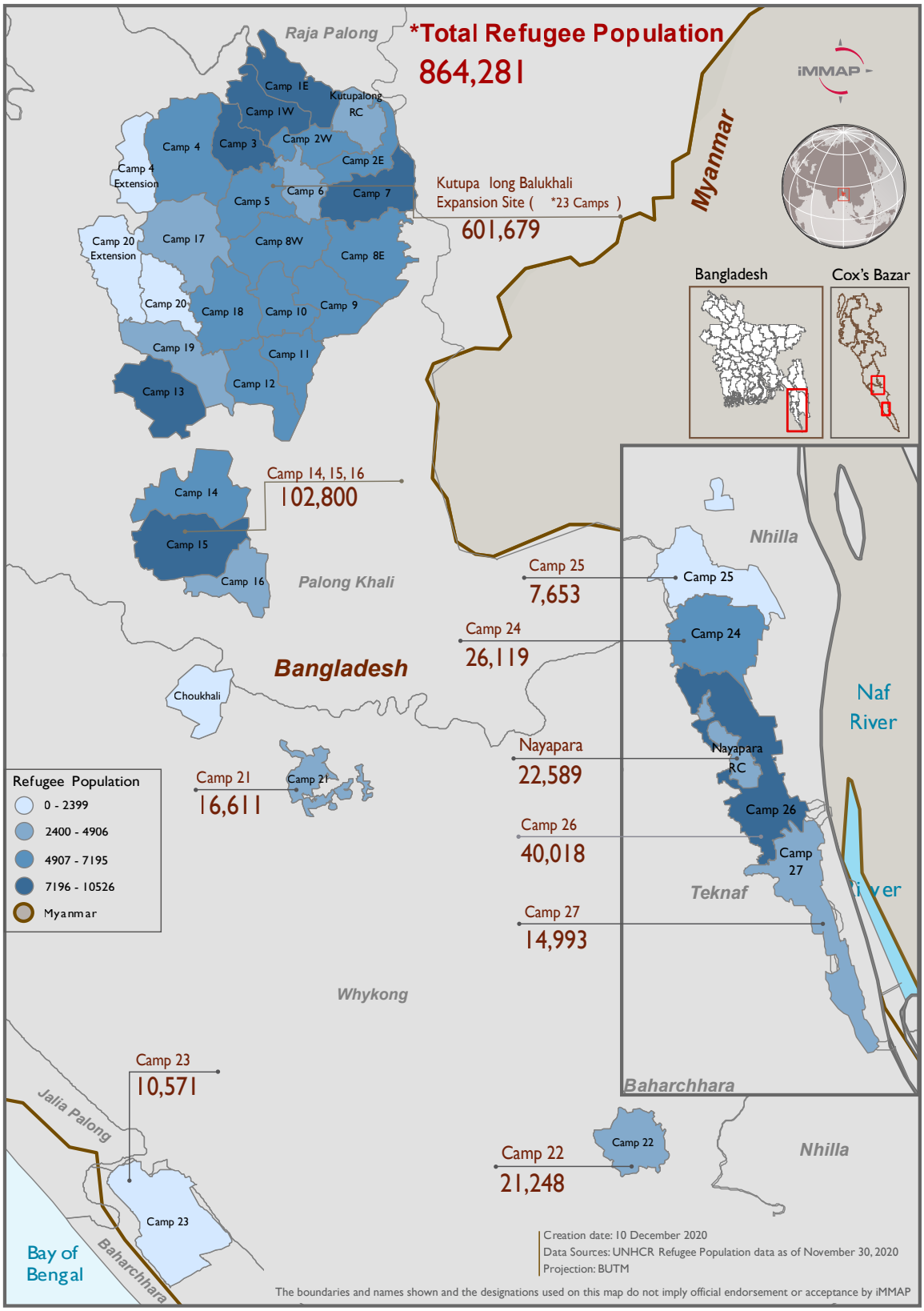

Containment measures
COVID cases
Economic
COVID-19 recorded cases nears 10,000
5/04/2020
+5,683 9,455 CASES +57 177 DEATHS
GoB Ministry of Public Administration extends general holidays till May 16
5/04/2020
+6,371 10,143 CASES +62 182 DEATHS
GoB Ministry of Health confirms first Covid-19 cases in Rohingya Refugee Camp
5/15/2020
GoB Ministry of Public Administration ends lockdown despite the rise in coronavirus cases
5/31/2020
+28,290 47,153 CASES +367 650 DEATHS
GoB Ministry of Civil Aviation and Tourism approves resumption of domestic commercial passenger flights on a limited scale.
6/01/2020
GoB Ministry of Education extends Closure of educational institutions until August 6
6/15/2020
+43,466 90,619 CASES +559 1,209 DEATHS
Directorate General of Health Services (DGHS) confirmed that coronavirus cases has exceed 100,000 in Bangladesh
6/18/2020
+11,673 102,292 CASES +134 1,343 DEATHS
Directorate General of Health Services (DGHS) confirmed that coronavirus cases has exceed 200,000 in Bangladesh
7/18/2020
+99,774 202,066 CASES +1,238 2,581 DEATHS
GoB Ministry of Health Bangladesh made wearing of masks mandatory for all.
7/21/2020
Directorate General of Health Services (DGHS) confirmed that coronavirus cases has exceed 300,000 with nearly 4,100 deaths in Bangladesh
8/26/2020
+100,081 302,147 CASES +1,501 4,082 DEATHS
WHO report confirm that coronavirus cases in Cox's Bazar exceed 4,500 with nearly 4400 host community people and 200 Rohingya refugees infected.
9/27/2020
WHO report confirm that coronavirus cases has exceed 400,000 with over 5,800 deaths in Bangladesh
10/26/2020
+98,104 400,251 CASES +1,736 5,818 DEATHS
WHO report confirm that coronavirus cases has exceed 434,472 with over 6,215 deaths in Bangladesh
11/16/2020
+34,221 434,472 CASES +397 6,215 DEATHS
WHO report confirm that coronavirus cases has exceed 464,932 with over 6,644 deaths in Bangladesh
11/30/2020
+30,460 464,932 CASES +429 6,644 DEATHS

Figure 3: Refugee Population by Camp



Source: UNHCR 31/10/2020

Context - Economic

Socio-economic Impact and Poverty Level in Bangladesh

The Nationwide containment measures imposed by the government of Bangladesh included lockdowns which shut down businesses and domestic economic activities across the country and resulted in the loss of millions of jobs. This led to a significant rise in the poverty rate and a projected shortfall in the country's GDP compared to the previous years. In the last ten years, GDP growth in Bangladesh has been strong, reaching an annual growth rate of 7.9% in 2019. In 2020 Bangladesh GDP was projected to fall to 2% due to economic downturns resulting from COVID-19 economic lockdowns (IMF 04/2020).

For the last 15 years, Bangladesh's poverty rate had steadily reduced from 40 percent in 2005 to 21.8% in 2017-2018 and 20.5 percent in 2019 (Dhaka tribune 08/2020; BBS 2019). Since the start of 2020, the General Economic Division's estimation reported that Bangladesh's poverty rate has risen to 29.5% as of June 2020 (a 9% increase from 20.5% in the 2018/2019 fiscal year), highlighting a decline in Bangladesh's socio-economic growth. The challenge with Bangladesh's socio-economic situation is that the High GDP growth rate has not effectively fostered faster poverty reduction (World Bank Group 2019).

The aftermath of the COVID-19 pandemic is likely to be millions of people pushed back into extreme poverty in 2020, especially people working in the informal economy, whose incomes dropped significantly since the start of the pandemic. This will make the achievement of Sustainable Development Goals (SDG) in Bangladesh even more challenging (SDG Report 2020).

Government Fiscal and Monetary Policy

The IMF has assessed Bangladesh's government economic and fiscal policies to be at low risk with reduced reliance on aid and prudent borrowing in recent years until the COVID-19 crisis. Due to the CoVID-19 pandemic, Bangladesh is anticipated to have an increase in external debt-to-GDP ratio from 36 percent at the end of 2019 to about 41 percent due to pandemic-related additional spending for health, education, infrastructure, and social protection amidst the dwindling economic situation of Bangladesh (IMF 04/2020).

Impacts on Trade and Labor Market

During the current global socio-economic downturn and the pandemic's uncertain course, trade is essential to saving lives and livelihoods. The impact of COVID-19 has also affected both local and international trade. The United Nations Conference on Trade and Development (UNCTAD) projects a 20 percent annual decline in trade for 2020 with a 5% drop in the third quarter of 2020 compared with the same period last year (UNCTAD 06/20; UNCTAD 10/20). In international trade, a major area of impact in Bangladesh is in the garment industry, which represents over 80 percent of Bangladesh's exports. The ready-made garments factories

have been significantly affected with an 83 percent fall in their year-on-year exports as of April 2020. Bangladesh's trade volume to GDP was at 31.5 percent in the 2018-2019 fiscal year, but it is unclear if a similar trade volume can be achieved in 2020. Most of the foreign export activities and trade are expected to pick-up toward the end of 2020. However, most of the desired changes will depend on how well domestic economic activities are coping during the crisis time and the speed of recovery in the post-crisis period (IMF 04/2020).

In local trade, the situation is similar when compared with declines on the international trade fronts. The dominant sectors in local trade in Bangladesh are agriculture and industry that jointly contribute 32% of Bangladesh's GDP and employ 60% of the total workforce (BBS 2018). Local trade in Bangladesh is hugely impacted by a combination of factors such as the job losses from the industries (especially in the Ready-made Garments factories where an estimated 24,000 jobs have been terminated) and declining consumer demand due to falling industry wages (Amit 2020; Mirdha 2020). To support strengthening foreign and local trade recovery efforts, the Bangladesh government has continued to target specific industries with intervention such as stimulus packages and intervening in the foreign exchange market to keep the exchange rate of BDT to USD relatively stable, enabling foreign-owned/controlled companies operating in Bangladesh to maintain business operations and meet actual needs for payments of wages and salaries (IMF 10/20).

Figure 4: World Economic Outlook Database for Bangladesh, October 2020

Main Indicators	2018	2019	2020	2021
GDP (*Billions USD*)	274.0	302.5	317.8	338.4
GDP (*Annual % Change*)	7.9	8.2	3.8	4.4
Government Gross Debt (*in % of GDP*)	34.6	35.8	39.6	41.9
Inflation Rate (%)	5.8	5.5	5.6	5.9

Source: IMF, October 2020

Employment and Labor Market

The global lockdown and movement restrictions affected Bangladesh's economic performance by reducing wages amongst those employed in the formal sector. In 2016–17, the economically active employed labor force (15 years and above) of the country was 60.8 million, of which 85.1% were informal workers. The share of informal workers is the highest in the agricultural sector, in which out of total 24.7 million employed workers, 95.4% of them are informally employed (BBS 2018).

Socio-economic Profile and Poverty Level in Cox's Bazar

Cox's Bazar remains one of the poorest and vulnerable districts in Bangladesh. The District Administration expects over 700,000 people in Cox's Bazar District to be affected by

unemployment resulting from COVID-19 related government restrictions (ISCG 04/2020). Reports from the World Bank Group on data collected during the lockdown show that about two-thirds of the host community population employed during the lockdown were not actively working or temporarily absent from work due to COVID-related restrictions.

Workers who receive income through wages were more affected by a temporary absence from work due to covid-19 lockdown, and they reported to have experienced a reduction in their earnings. In contrast, non-wage workers were more affected by a decrease in their income, resulting from lockdown measures. For instance, The COVID-19 mobility constraints at Rohingya camp led to a closure of all site development works, shops & other IGA's , many of which were staffed by refugees & host population (IRC 08/07/2020). Overall, Individuals involved in home-based agricultural income sources in Cox's Bazar were less severely affected than individuals in service-sector jobs (World Bank Group 07/2020). In the aftermath of the COVID-19 lockdowns, the loss of livelihoods was compounded by unpredictable wage rates resulting in a decrease in consumer demand and purchasing behavior for many families in host communities and refugee camps (WFP 09/2020).

COVID-19 Epidemic Overview

The first cases of COVID-19 were confirmed in Bangladesh on 8 March (Reuters 08/03/20). The Government declared a public holiday from 26 March to 30 May, closing government offices and non-essential businesses and restricting movements. The COVID-19 caseload has declined since the second peak in mid-August, but positive cases showing a steady increase since October. COVID-19 testing for November reduced to almost 420,000 tests when compared to October. While most containment measures have been rescinded, public health measures such as wearing masks are still in place.

Figure 5: Total tests, COVID-19 cases and deaths for Bangladesh (WHO sit reps)

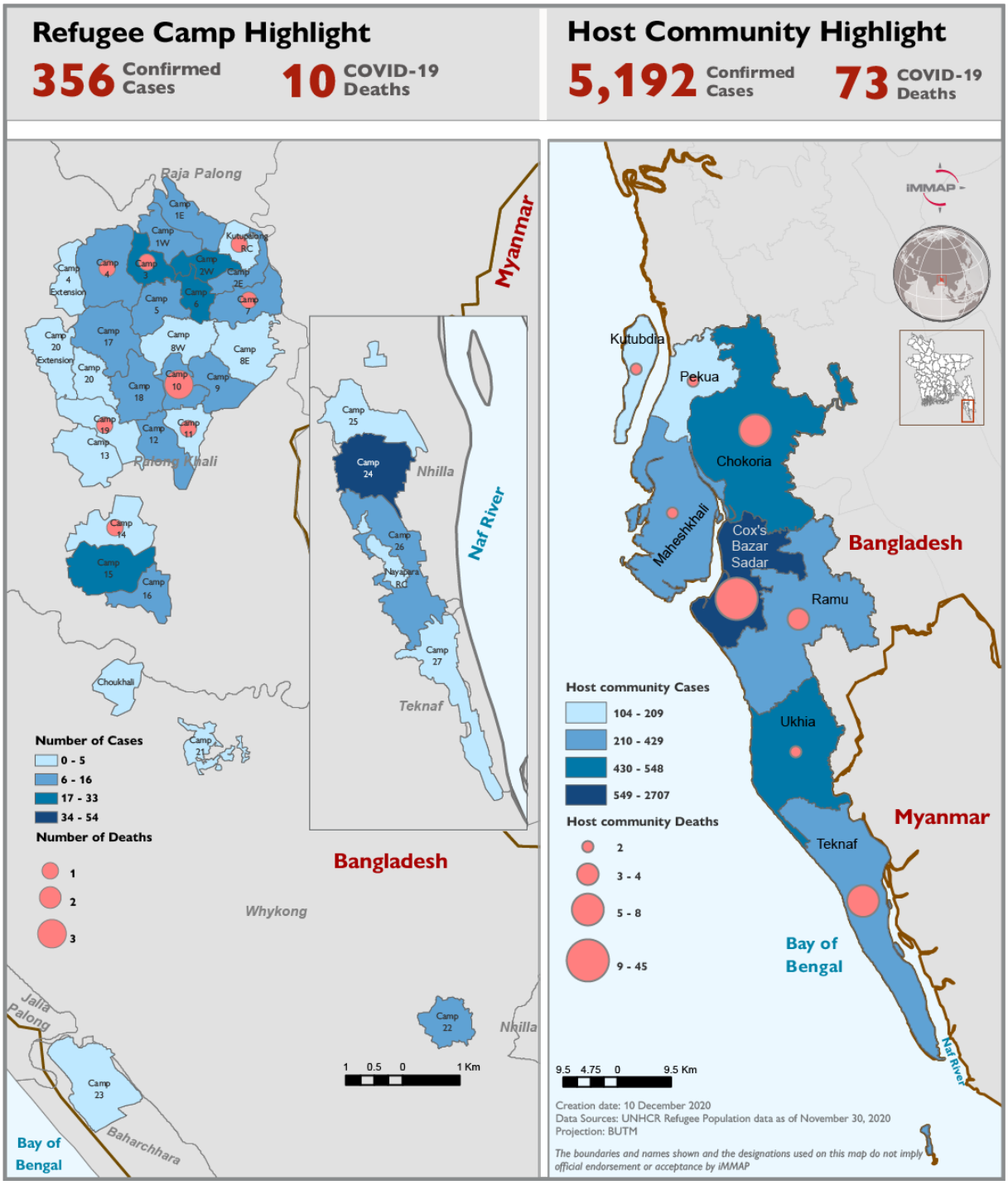
Bangladesh	31-Aug	28-Sep	02-Nov	30-Nov
Total # of tests conducted	1,550,203	1,921,382	2,361,702	2,772,701
Total confirmed cases	312,996	360,555	410,988	464,932
Total deaths due to COVID-19	4,281	5,193	5,966	6,644
Tests this month	425,786	371,179	440,320	410,999
Cases this month	86,771	47,559	50,433	53,944
Deaths this month	1,316	912	773	678

Cox's Bazar

Cox's Bazar is one of the country's poorest and most vulnerable districts, with a total Bangladeshi population of 2,650,000, and it is host to some 860,000 Rohingya refugees. Cox's Bazar reported its first official case of COVID-19 on 24 March and the first casualty on 24 April 2020 (WFP 07/09/2020). It was not until 14 May that the first confirmed case of COVID-19 was reported in the refugee camps, but testing until then had been limited, with only 80 tests in total carried out by 12 May (Independent Diplomat 27/07/2020, WHO 12/05/2020).

The Trajectory of COVID-19 in Cox's Bazar

Figure 6: COVID-19 Cases in Cox's Bazar as of 29th November 2020



Data Source: WHO 01/12/2020

For the Host Communities, the number of newly reported cases plateaued to around 63-80 per week in November following a sudden spike of over 100 cases per week during the last week of October. In the refugee camp sites, there were over 20 refugee cases reported in the past 4 weeks (compared to 63 cases within a similar period in October). Generally, the trend suggests that the feared second wave or serious outbreak in the camps has not occurred (WHO situation reports August to November 2020).

Figure 7.1: Cox Bazar Host community weekly tests conducted and new cases identified *(WHO situation reports August to November 2020)*

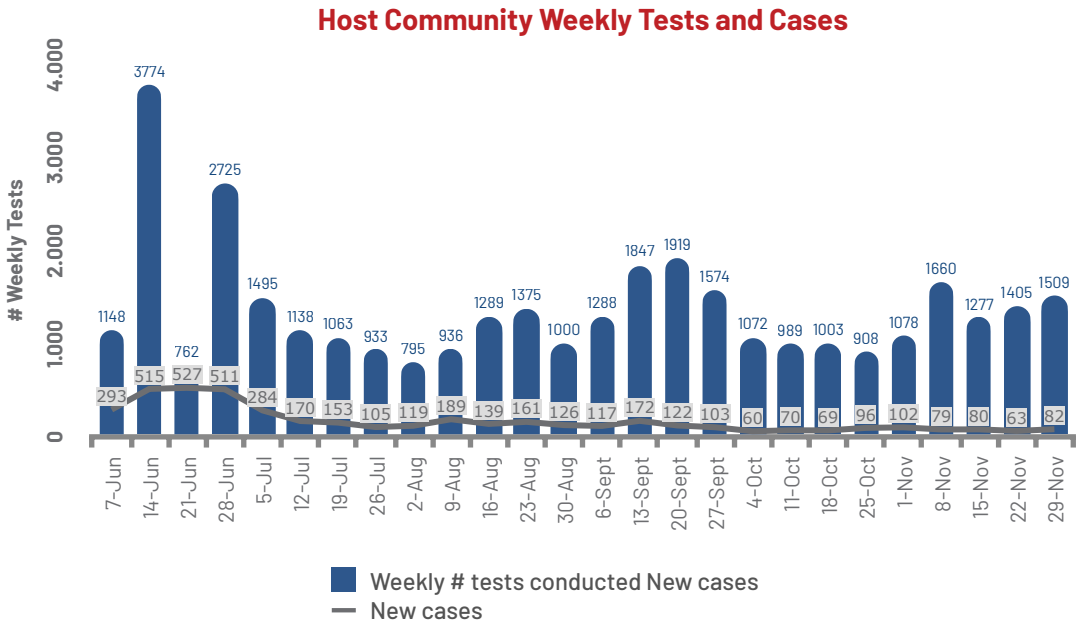
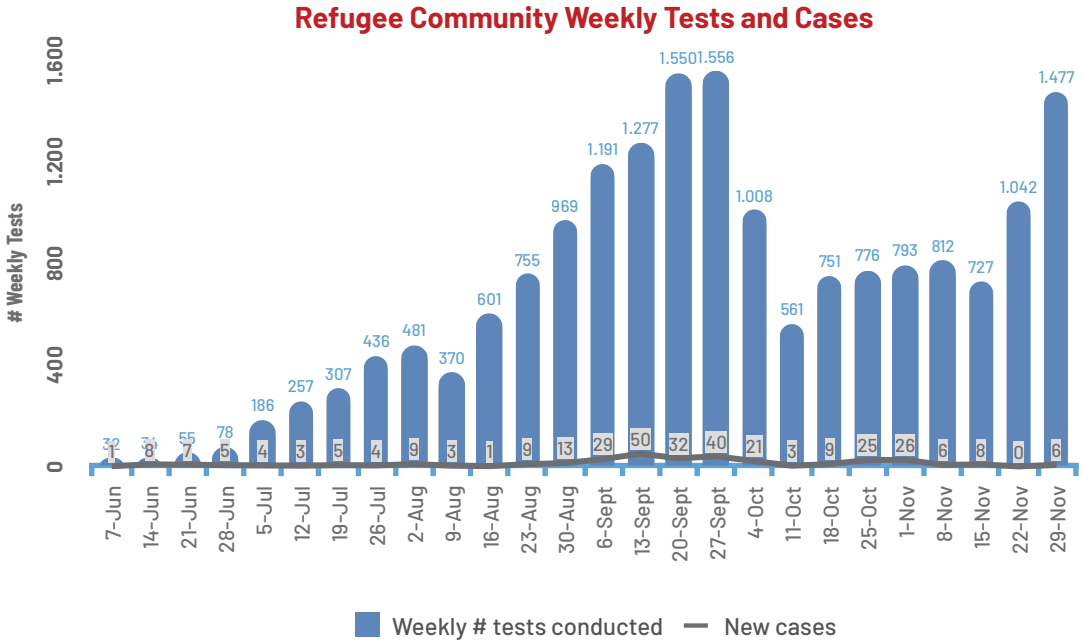


Figure 7.2: Cox Bazar Refugee community weekly tests conducted and new cases identified *(WHO situation reports August to November 2020)*



Overall, the number of patients in isolation remained relatively stable in the host community and dropped from 101 at the beginning of the month to just 35 by 29 November for the refugee communities (WHO situation reports August to November 2020).

Figure 8.1: Cox Bazar total confirmed COVID-19 cases and number of persons in isolation for Host Community *(WHO situation reports August to November 2020)*

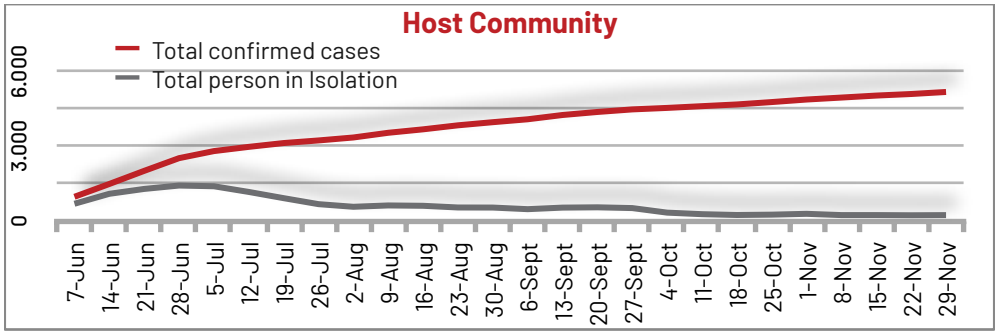
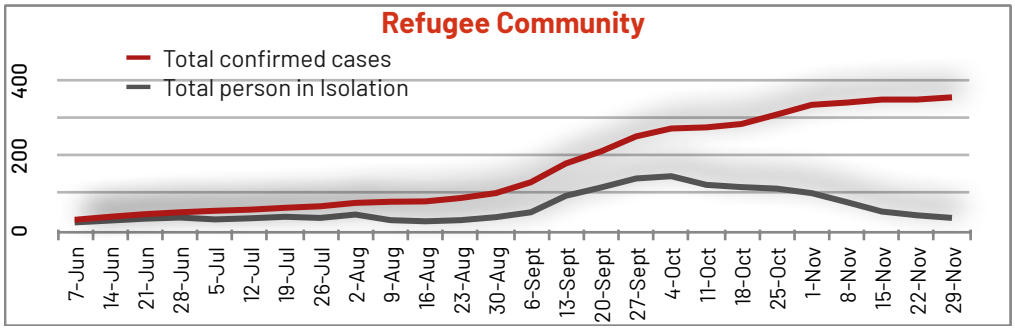


Figure 8.2: Cox Bazar total confirmed COVID-19 cases and number of persons in isolation for Refugee Community *(WHO situation reports August to November 2020)*



Future Risks and Mitigation Efforts

With the easing of movement restrictions and increased humanitarian footprint in the camps, efforts are being made to prevent and prepare for a future outbreak. Confirmed cases of COVID-19 in the refugee camps remain lower than initial estimates (20 new cases during the last reporting period in November) (WHO 01/12/2020).

Vaccinating the most at-risk populations against COVID-19 is one of the most effective ways of curbing the COVID-19 pandemic. Preliminary discussions on a possible COVID-19 vaccination campaign for Rohingya refugees have started in alignment with the National Deployment and Vaccination Plan for COVID-19 vaccines (WHO 28/10/2020).

Testing and COVID-19 patient care capacities are being expanded. Twenty-five sample collection sites are currently operating for COVID-19 sample collection (WHO 28/10/2020), additional testing facilities in 13 camps are under review (WHO 04/10/2020).

Three additional SARI ITCs are in the process of being established, which will provide a further 159 beds. However, SARI ITC beds' occupancy rate has reduced to no more than 20-30% over recent weeks, reflecting the downturn in COVID-19 cases. There are currently 578 beds available to receive patients, and another 528 are on standby (WHO 21/10/2020). Also, The WHO Infection Prevention and Control (IPC) team is continuing to train health care workers in the adequate management of patients with COVID-19 (WHO 21/10/2020).

COVID-19 Containment Measures

While many of the COVID-19 containment measures have been lifted, restrictions remain for humanitarian activities within the camps. Organizations are required to follow protocols to contain the spread of COVID-19, including physical distancing, handwashing, and mask-wearing. Schools continue to be closed.

COVID-19 Containment Measures at the National Level

The first cases of COVID-19 were confirmed in Bangladesh on 8 March (Reuters 08/03/2020), and subsequently, mitigation policies were introduced, including lockdown and curfew measures alongside movement restrictions. Although the measures were primarily aimed at stopping the spread of the virus, these measures also had a significant negative impact on an economic and social level, adversely affecting both livelihoods and the provision of basic services.

Many of the countrywide restrictions have now been lifted, although mitigation measures remain in place, including screening and quarantine procedures at international airports. Perhaps the most significant measure not yet rescinded was the closure of all educational institutions on 17 March (IFRC 17/07/2020). The country has extended the closure of educational institutions until December 19 amid the risk of a second wave of Covid-19 infections during the coming winter (United News of Bangladesh 13/11/2020).

Containment Measures in Cox's Bazar

In line with the COVID-19 containment measures introduced countrywide, similar measures were also introduced for Cox's Bazar. These restrictions had a large negative impact on both Rohingya refugees' livelihoods and more severely on the income of Host Community households (ISCG Gender Hub 14/10/2020).

In an attempt to limit the spread of COVID-19, humanitarian operations were limited to those identified as "critical services and assistance" (RRRC, 08/04/2020). "Non-essential" interventions were scaled down or suspended, including activities such as health education and community mobilization for TB awareness (WHO 26/08/2020). Restrictions also reduced the provision of humanitarian services and forced agencies to adapt working practices. For example, food distributions were changed from bi-monthly to once a month to reduce contact time with beneficiaries (IOM 22/07/2020).

The list of "essential" interventions was expanded after a revised version of the protocols was issued in July (Interview Site Management 15/11/2020). Humanitarian operations allowed continued use of preventative measures, including social distancing, handwashing, and use of personal protective equipment by staff. In addition, social distancing and hand washing by beneficiaries is promoted at distribution points. On arrival, beneficiaries are encouraged to

wash their hands. Mobilization for distribution is carried out one block at a time, with bamboo sticks and markings used to indicate where to stand to ensure a one-meter distance. Additional temporary distribution points have also been created to help prevent overcrowding (IOM 16/10/2020).

Another critical measure is the continued screening of passengers and pedestrians at points of entry (POE) to the camps. Sixteen out of nineteen POEs are functional, and between 23 to 29 November 2020, a total of 43,302 individuals were screened and, where necessary, provided education and referral to health facilities. Site Management teams continue to coordinate the campaign "No Mask No entry in Service Point" with all service providers (WHO 01/12/2020, IOM 24/11/2020).

However, for the Rohingya refugees, the overcrowded conditions in the camps, the hilly terrain, uneven access to a limited number of WASH and health facilities, and shortages of protective and hygiene items have hampered their ability to follow the preventive measures necessary to limit infections (ISCG 14/10/2020).Humanitarian partners completed the distribution of over 2,855,850 reusable masks in all 34 Rohingya refugee settlements in Cox's Bazar and all 8 Upazilas throughout Cox's Bazar District, as a critical measure for preventing the spread of the COVID-19 pandemic (ISCG 21/10/2020).
Despite efforts, including mask distribution and the set-up of hand-washing facilities throughout the camps, compliance rates remain low (Interview Site Management 15/11/2020).

Information and Communication for Covid 19

Overall, information and communications efforts are continuing with improved coverage for the most part due to the lifting of most of the restrictions on humanitarian programming in the camps. Recent studies show differences in how the host community and refugee community access information. Gender and age also play a role in preferred information sources and the trust level placed in various sources.

Information Channels and Means

With the lifting of many movement restrictions, humanitarian actors were able to step up community engagement around key COVID-19 messaging. Key messages were provided through community consultation and awareness meetings, listening group sessions, communication sessions conducted by religious leaders, and loudspeakers/megaphones. Video and audio materials were developed and used to support these sessions (ISCG 18/10/20, WHO 07/10/2020, WHO 14/10/2020).

WHO, through its involvement in the Communications with Communities Working Group (CwC WG) and the Risk Communication and Community Engagement Working Group (RCCE WG), continues to coordinate with agencies across the response to ensure that all information

around COVID-19 and health issues are of high quality, technically correct and easily understandable by communities (WHO 01/12/2020).

Sector members and partners introduced some new information channels and means, arranged courtyard discussion to maintain health norms, introduction of a hotline, formation of radio listening groups and stronger relationship with community leaders and religious leaders were treated as major information channels and means (CWCWG interview Inputs 02/12/2020).

Information Challenges

COVID-19 and related measures created challenges in understanding how an increased focus on COVID has impacted on data collection and data sharing activities for regular humanitarian programs. It has affected overall data collection due to limited engagement with the community, reduced number of volunteers, reduced number of camp workers, and less comfort of respondents in ICT based data collection tools. COVID-19 also affected sector members' capacity to mobilize staff in conducting assessments and data collection due to less access, lower sample size, and lower number of events (sometimes no event). As well as COVID affected sector analysis activities due to lower collaboration opportunities in analyzing data.

COVID-19 and related measures affected the capacity of coordination mechanisms by impacting the regular participation, number of attendees, the modality of conducting meetings due to limitation in effective participation of partners, and lack of bilateral communication between partners (CWCWG interview inputs 02/12/2020).

A study by the ISCG Gender Hub found that some factors influenced which information sources were trusted and relied upon. Differences between the refugee and host communities were also noted through the J-MSNA.

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. For women, door-to-door visits were preferred, and some will rely on male relatives for information. Men, on the other hand, preferred loudspeaker announcements (ISCG Gender Hub, 14/10/2020). Language and poor mobile connections are the main barriers to accessing information. The vast majority of Rohingya households (94% or more) reported having enough information on COVID-19 precautionary measures, points of contact, and symptoms/vulnerable groups (ISCG 18/10/20).

Host communities cited technology as the preferred source of information, with both men and women trusting news provided via television. The main difference was women's preference for social media as an information source compared to men's for radio.

Local authorities are cited by both men and women in the host community as trustworthy sources of information (ISCG Gender Hub 14/10/2020). Despite movement restrictions, there are no significant barriers to information; those who do not own mobile phones and age were all flagged as factors that can reduce access (ISCG 18/10/20). Respondents cited Uthan Boithok (yard meetings) to be very effective for information sharing. While 97% of households reported having enough information on COVID-19 precautionary measures, this dropped to 86% for points of contact and only 82% for enough information on symptoms/vulnerable groups (ISCG 18/10/20).

Religion plays both a positive and inhibiting factor for both host communities and refugees in the trust and perception of COVID-19 messaging. Some respondents (especially older people) mentioned that prayer could help prevent COVID-19 and believed that God would protect them, and therefore they were less likely to take precautionary measures. On the positive side, religious leaders are trusted sources of information and are being used to provide critical COVID-19 messaging (ISCG Gender Hub 14/10/2020, ISCG 02/10/2020).

Overview of Impact and Humanitarian Conditions

The findings below reflect that at the time of reporting, most available information covered the period during or just after the lifting of many of the COVID-19 containment measures. The J-MSNA, for example, undertook data collection in July and August 2020. Therefore, it is unclear how long-term the effects of COVID-19 containment measures are or how long some remaining measures will continue to be enforced. Currently, there are fears of a second wave with the number of positive cases increasing slightly for November after a sharp drop in October. Measures such as the continued closure of schools remain in place.

COVID-19 containment measures have had a significant negative impact on both the refugee community and the host community in cox's Bazar:

- ***Sexual and Gender-Based Violence*** *continues to be a major issue; this is linked to the economic impact of COVID-19 containment measures and an increasingly insecure environment in some of the camps.*
- *Overall, there* ***continues to be a reported rise in child protection issues,*** *including child labor, child marriage, and reports of children going missing. Violence against children in the homes and in communities is also a concern, as confinement, together with increased stress and anxiety leads to negative coping mechanisms. The situation of children is partly driven by the continued closure of education centers and loss of livelihoods and income.*
- ***Schools remain closed,*** *with fears of a second wave of COVID-19 infections. Children (especially adolescent girls) face many challenges in engaging with distance learning and home-schooling. Concerns remain on how many children will not return to education once schools reopen.*

- ***COVID-19 containment measures**, **the fear of catching COVID-19,** and the **stigma** attached to the disease have all been factors in a **decreased use of health services** by both refugees and host communities and a reduction of programs such as family planning and immunization services.*
- ***The majority** of pregnant/lactating women and children aged 6-59 months in **refugee households are enrolled in nutrition feeding programs**, but the figure is much lower for host communities due to operational differences in nutrition interventions.*
- *Due to **COVID-19 restrictions** and widespread **damage** from **heavy rains and flooding,** there are **significant shelter needs in many camps**. However, the relaxation of some COVID-19 restrictions has allowed the shelter sector to scale up its response.*

Protection

The continued worsening of the security situation in some camps and the resulting increase in protection issues is concerning. Insecurity and the economic impact of COVID-19 containment measures drive an increase in Sexual and Gender-Based Violence.

Overall, there continues to be a reported rise in protection issues, in particular Intimate Partner Violence (IPV) and violence in the home. Child labor is a significant concern in host communities and a worrying rise in reports of children going missing in refugee communities. Increasing levels of child marriage are also flagged as a concern in both communities. Children's situation is partly driven by the continued closure of education centers and by the loss of livelihoods and income that has put financial pressure on households, leading to the adoption of negative coping mechanisms.

Information Sources, Gaps and Challenges

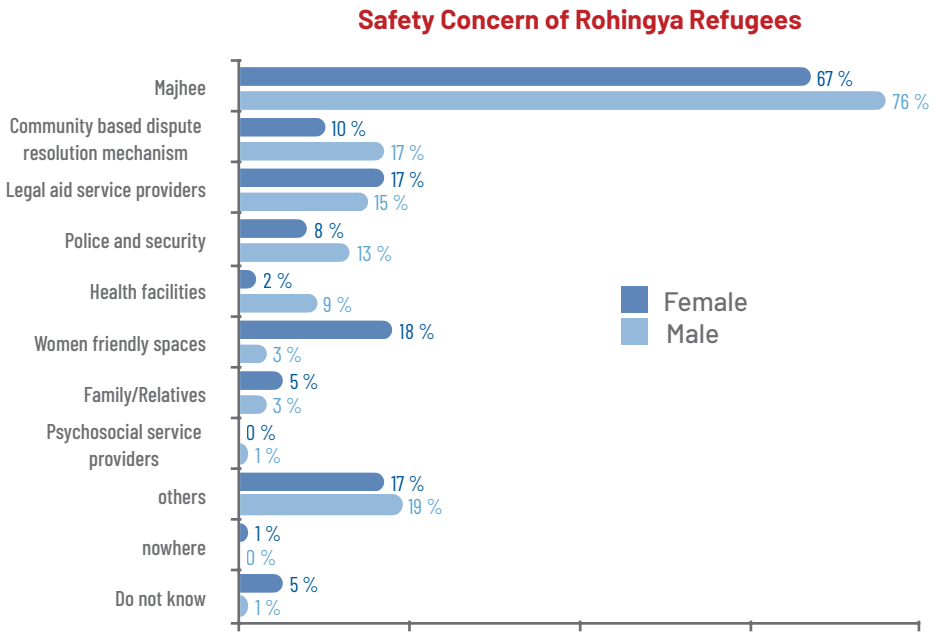
A recent advocacy brief from UN Women provides an analysis of the situation facing women in the refugee camps (although little information on the methodology or sources of data is available for the piece). Some quantitative data on the prevalence of protection issues in the community was available from the J-MSNA. The ISCG Gender Hub study is still relevant and provides a more in-depth examination of issues (including protection) affecting specific groups and disaggregated by gender. Finally, the latest Protection Factsheet (September) gave a more recent update of key issues. However, there is a lack of current protection data to understand how the situation has evolved as the provision of humanitarian services returns towards pre-COVID levels. Primarily gaps in terms of accurate information for protection issues are due to the reduced humanitarian footprint, reduced avenues for reporting and therefore a reliance on anecdotal evidence from camp focal points to draw an overall picture of the protection environment.

Increased insecurity is leading to a rise in protection issues

Increasing insecurity continues to be a driver of protection issues in several of the refugee camps. There has been a reported steady growth in violent confrontation in the camps since

January 2020 (UNDP CARU), with escalations in violence between armed gangs and conservative forces since July 2020, especially in the northern camps (1 East, 1 West, 2, 3 around Kutupalong and Nayapara registered camps), as well as in Teknaf camps. This drives an increase in protection incidents and serious crimes such as robbery, intimidation, drug trafficking, arbitrary killing and arrest, murder, and abduction (UN Women 27/10/2020, UNHCR 19/10/2020).

Figure 9: Reporting the safety concern for the Rohingya refugees



Source: Compiled from: J-MSNA 12/11/2020, J-MSNA 12/11/2020

Thirteen percent of households reported any security issues of concern since the COVID-19 outbreak, largely theft (11%) (J-MSNA 12/11/2020). However, the recent UN Women study indicates that many women are afraid to report crimes, particularly GBV.

Protection actors report a rise in Gender-Based Violence (GBV) with pre-existing risks being exacerbated

Evidence suggests that the worsening security situation, the negative impact of COVID-19 containment measures, and the continued reduced presence of protection actors increase the risk of GBV within a number of the refugee camps. There has been a reported increase in GBV and security risks for women, girls, and transgender persons in the camps and host communities, including physical and verbal harassment, kidnapping, child marriage, forced and reparation marriages, and human trafficking, as well intimidations and threats against Rohingya women leaders and volunteers, especially in Teknaf camps and northern camps adjacent to Kutupalong Registered Camps (ISCG 01/11/2020).

While formal GBV reports have declined, anecdotal evidence indicates that incidents are rising, as is the severity of incidents reported. Moreover, women and girls are reportedly

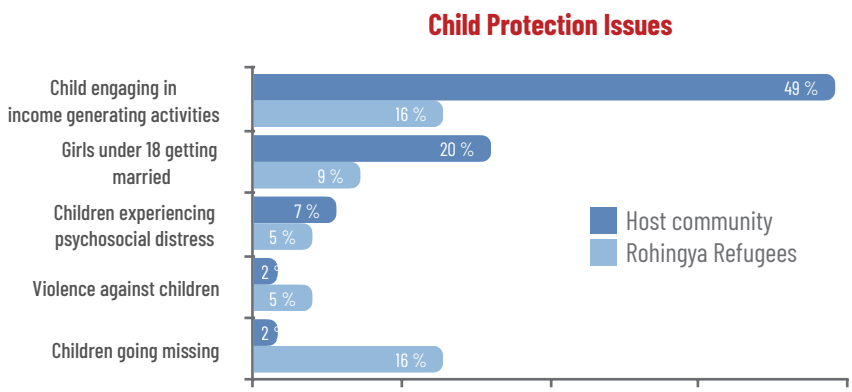
refraining from seeking medical services in reproductive health clinics due to fears associated with being identified as or having been exposed to COVID-19 patients (IOM 30/11/2020). Domestic violence is the most reported form of GBV in the camps, according to the most recent GBV Information Management Systems report. In addition, GBV risks are high in the congested camps (UN Women 27/10/2020).

Continued reduced access to reporting mechanisms, protection, and security services during the COVID-19 pandemic remain concerning. This followed from a reduction introduced by the Government in the types of activities allowed in the camps, hence reducing the number of GBV service facilities to only individual case management (ISCG 01/11/2020, UN Women 27/10/2020). In addition, Rohingya women have little confidence in police and camp authorities' ability to respond to their needs, and many women fear they will be arrested or deported to Myanmar if they report a crime in Bangladesh. Furthermore, the stigma for GBV survivors is high. When perpetrators are known, other factors prevent women from seeking access to justice (UN Women 27/10/2020).

With schools, education centers, and child-friendly spaces still closed, communities are seeing an increase in child labor, child marriage, and child trafficking and violence against children

The closure, without alternatives being provided, of all multi-purpose centers, learning centers, and child-friendly spaces has resulted in negative coping mechanisms impacting children and adolescents. The loss of work opportunities across the camps and resultant financial pressure has led to increased child labor and child marriage. In some instances, children and adolescents have also become involved in the drug trade and petty crime, such as theft. Most of the reported child protection cases have been categorized as high risk, including SGBV, child marriage, violence, and child labor (UNHCR 18/10/2020, ISCG Gender Hub 14/10/2020). Increased household tensions are leaving children and adolescents at a greater risk of abuse, neglect and violence (ISCG Gender Hub 14-10-2020). Nine percent of refugee households and 20% of host community households reported an increase in underage marriage in their community in the previous six months (J-MSNA 18/10/2020).

Figure 10: Increasing in Child protection issues in both refugee and host communities in Cox's Bazar



Source: Compiled from: J-MSNA 12/11/2020, J-MSNA 12/11/2020

Risk of child trafficking in particular continues to be a major concern in a number of camps, mostly involving girls and often relating to child marriage, with the promise of economic stability through marriage being used to lure victims into trafficking and smuggling schemes (UNHCR 19/10/2020). Sixteen percent of refugee households reported an increase in children going missing in their community in the previous six months, the figure was 2% for host community households (J-MSNA 18/10/2020).

Violence against children as well as children witnessing domestic/intimate partner violence continues to be a prevalent issue in biweekly reports to the CPSS from camp focal points and is confirmed by the case management information management system (CPSS 17/12/2020).

Host communities are also under financial pressure. Cox's Bazar has a high level of child labor, with 8% of households in host communities reporting at least one child working (ISCG Gender Hub 14/10/2020). Sixteen percent of refugee households reported an increase in child labor in their community in the previous six months, which rose to a 49% increase reported by host community households (J-MSNA 18/10/2020).

Local media provided comments from a meeting between representatives of children's forums and local officials (facilitated through a Save the Children project). The reports highlighted that children believed COVID-19 containment measures and the subsequent pressure on livelihoods and household income was driving up child labor and child marriage (dhakatribune, 29/11/2020, United News of Bangladesh, 29/11/2020).

Women, girls, and female-headed households are particularly vulnerable

The socio-economic impacts of COVID-19 resulted in the deterioration in safety and security for women and girls in the camps, with an increase in SGBV and a decrease in access to protection services (UNHCR 06/2020, IOM 30/11/2020). These barriers make female-headed households and households with no males of working age harder to reach and forces them to adopt negative coping mechanisms, further reducing their already diminished wellbeing (ACAPS, 04-10-2020).

Inadequate lighting and the placement of latrines and water points continue to cause protection concerns for women and girls who are disproportionately affected by poor sanitation and hygiene facilities. Women continue to report feeling unsafe to use WASH facilities that are not adequately separated by gender and not well lit at night. To avoid being seen bathing and defecating, women reportedly wash and defecate inside their shelters, restrict food and water intake, and restrict movement during their menstrual period (UNHCR 19/10/2020, UN Women 27/10/2020).

Education

Schools remain closed and children face many challenges in engaging with distance learning and home-schooling. The continued school closure is having a negative effect on children's wellbeing and putting them at increased risk. Concerns remain on how many children will not return to education once schools reopen. School reopening has been delayed again (until 19 December) due to the fear of a second wave of COVID-19 infections. National exams have also been cancelled.

Information sources, gaps and challenges

With schools closed, education provision is via distance learning and home-schooling. However, it is difficult to ascertain to what extent home learning is taking place. Factsheets from the J-MSNA give some quantitative data including information on numbers of children expected not to return to school. There are some updates from local sources on the expected timetable for school reopening. There is a short situational analysis within the education sector COVID-19 response strategy, along with a study by the ISCG Gender Hub (conducted in June) that provides some a gender lens on education issues. Finally, a link to global perspective is supplied by a UNICEF paper.

Schools and education centers remain closed

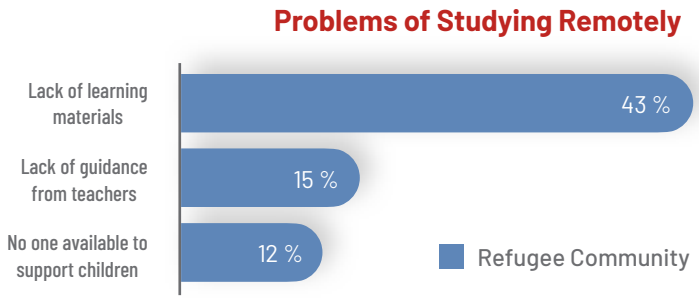
The school closure which had started since March has been extended until 19 December due to the fear of a second wave of COVID-19 during the coming winter. Also, the Higher Secondary Certificate and equivalent examinations as well as Primary Education Completion and its equivalent Ebtedayee examinations for 2020 were cancelled (United News of Bangladesh 19/11/2020, Dhaka Tribune 24/11/2020). The closure of schools and education centers continues to impact the learning of over 325,000 refugee children as well as many more in the host community. These students are missing vital learning opportunities and have had their social support systems further disrupted (Education Sector 12/10/2020).

Both refugee and host communities cited the impact of the lockdown on education as a general concern aside the loss of education, key informants also mentioned less regular daily routines as a risk to children's wellbeing (J-MSNA 18/10/2020).

Distance learning support stepped up, but challenges remain

Although many refugee children are engaged in learning remotely (86% of individuals that attended any form of learning before the COVID-19 outbreak were reported to have continued learning remotely) (J-MSNA 12/11/2020), it is clear that distance learning is challenging for most Rohingya children. The main challenges cited for remote learning are lack of learning materials (43%), lack of guidance from teachers (15%), and no one available to support the children (12%) (J-MSNA 12/11/2020).

Figure 11: Problems of studying remotely for Rohingya refugee children



Source Compiled from: J-MSNA 12/11/2020, J-MSNA 12/11/2020

For both refugee and host refugee communities, the lack of educational attainment or lack of time means that parents and caregivers are unable to support home-schooling (Education Sector Cox's Bazar 12/10/2020, ISCG 18/10/20). Both communities cited the lack of money to pay for private tuition as a barrier (ISCG 18/10/20). Girls from both communities are expected to support house and care work and therefore are likely to face more difficulty allocating time to home-schooling than boys (ISCG Gender Hub 14/10/2020, ISCG 18/10/20). In a consultation with children organized by Save the Children, participants highlighted that classes on modern devices using the internet are expensive and may effectively exclude disadvantaged children (Dhaka Tribune 29/11/2020).

School closure is putting children physical and mental wellbeing at risk

School closures and a lack of a normal routine is negatively impacting the health and wellbeing of children in both the Rohingya and host communities. The continued closure of learning centers and child friendly spaces due to COVID-19 is having a marked negative impact on children's education and wellbeing (ISCG 01/11/2020). Being out of school also increases the risk of teenage pregnancy, sexual exploitation, child marriage, violence, and other threats (UNICEF 12/10/2020). Rohingya youth volunteers reported an increase in the marriage rate for girls below 18 years. Boys also seem to be at risk. The closure of temporary learning centers and schools, the partial closure of child-friendly centers, 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 (ISCG Gender Hub, 14-10-2020).

Many children may not return to school

For the refugee community it was reported that 9% of individuals [that attended any form of learning before the COVID-19 outbreak] would not be sent back to school. The top three reasons cited for this were: children needed at home to help the family (12%), The learning center is too far (10%), Children will not go back for marriage (10%). 32% of the time the household preferred not to give a reason. The reasons would imply that girls will be disproportionately affected as they are more often asked to help with chores around the home as well as being more likely to have an early marriage (J-MSNA 12/11/2020). Even before

COVID-19, only one-third of Rohingya adolescent girls attended learning centers, compared to two-thirds of adolescent boys (ISCG Gender Hub 14/10/2020).

For the host community the completion rate for primary schools was already low (54.8% against a country average of around 80%) (IOM 22/07/2020). 31% of households report at least one school-aged child (age 5-17) not having attended any formal learning before the COVID-19 outbreak. However, it was reported that only 3% of individuals [that attended any form of learning before the COVID-19 outbreak] would not be sent back to school. Reasons were similar to the refugee community (marriage, children needed to help at home, could not afford to send children back to school and children not safe at school).

The long-term closure of schools and education centers, added to the economic impact of COVID-19 containment measures on poor households, threatens both refugee and host community children's education. A worldwide position paper from UNICEF outlines how disruptions to instructional time in the classroom can severely impact a child's ability to learn. The longer marginalized children are out of school, the less likely they are to return. Children from the poorest households are already almost five times more likely to be out of primary school than those from the richest (UNICEF 12/10/2020).

Health

Information sources, gaps and challenges

There are a wide variety of sources for the health section. Detailed findings of health needs and behaviors are provided by the J-MSNA including comparisons to 2019. The monthly health updates from WHO and IOM which include information from the Mental Health and Psychosocial Support (MHPSS) sub-sector provided additional information though often the origin/sample size etc. was not clear. The ISCG Gender Hub study provided a more in-depth examination of issues particularly in regards to women's health. A rapid urban assessment by CARE and a Bangladesh-wide assessment from World Vision helped fill in the picture for the host communities. A variety of other INGO and UN reports were also referenced. There was a lot of information on what and how the health situation changed, but much less detail on why (issues were identified, such as stress, depression, lack of transport to health centers etc. but the prevalence was often missing).

There was a decrease in health seeking behavior and in households reporting health issues in both Rohingya and Host Communities

- Within the refugee community 9% of individuals reported having had an illness serious enough to require medical treatment or to have required a regular medical check-up [in the 30 days prior to data collection]. This is a significant drop from 2019 when the figure was 35%. 94 percent sought treatment with the majority (64%) attending an NGO clinic. In line with the decrease in health needs, the prevalence of coping mechanisms for health also decreased:

- Only 41% of households reported paying for health care (down from 57% in 2019)
- Only 35% of households reported going into debt to pay for health care (down from 66% in 2019)
- Finally, 27% of households reported seeking lower quality/cheaper healthcare/ medication, more than double the proportion from 2019 (which was 12%)

(J-MSNA 18/10/2020)

There are various factors influencing this change in behavior. Firstly, the distrust of authorities and fear of catching COVID-19 played a role. A significant proportion of this reduction is likely due to changing health-seeking behaviors as evidenced by the two-thirds reduction in the number of consultations for Acute Respiratory Infections (ARI). In addition, since the COVID-19 response began in the camps in late March, the total number of consultations dropped over 50% (IOM 19/07/2020). 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. It was not just fear of COVID itself, but the consequences of testing positive. 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 center (ISCG Gender Hub 14/10/2020).

Containing the spread of COVID-19 has also meant increased restrictions on movement in the camps. This has further hampered access to healthcare and made it harder for patients with 'invisible' illnesses, such as psychiatric disorders or non-communicable diseases like diabetes, to prove that they are sick and to travel to medical facilities (Médecins Sans Frontières 25/08/2020). Finally, many of those with supplemental incomes (such as NGO volunteer program workers) saw a loss in income, which may have led to some households' de-prioritization of health care.

In the host community 14% of individuals were reported as having had an illness serious enough to require medical treatment or to have required a regular medical check-up. This is also a significant drop from 2019 when the figure was 31%. 97% of the individuals affected sought treatment, with the most popular health service options being: Pharmacy /drug shop in market (41%); Private clinic (36%); and Government clinic (27%).

There was a change in coping mechanisms within the host community. 83% of respondents reported paying for healthcare (up from 53% in 2019). This contrasted with only 34% of respondents going into debt to pay for health expenses, down from 53% in 2019. Seeking lower quality/cheaper health care/medication was roughly unchanged (at 19% compared to 15% in 2019). However, 16% of respondents cited seeking community support to pay for health care, an increase from 4% in 2019.

With lockdown measures it was more difficult to access normal avenues for loans or credit. One explanation would be that this forced households to either pay for health care or seek

community support as banks and other money lenders were closed. Both finance and transport were barriers to healthcare access. A small-scale study conducted at the end of April found that 71% of respondents who were pregnant reported that they had missed their routine ANC check-ups as the health facilities were closed as there were no transportation facilities to help them arrive at those facilities, and some responded that they didn't have enough money to continue ANC check-ups (CARE 01/07/2020).

There has been an increase in anxiety and depression amongst the refugee community

There has been a widespread impact on the mental health of both the Rohingya and the Host community. Consultations with the refugees, including women and adolescent girls, showed increased anxiety and stress stemming from the COVID-19 situation. As the primary caregivers in the household, women may experience a greater impact on their mental health as they will be directly exposed to the trauma of supporting those who contract the virus (IOM 22/07/2020).

In September IOM's MHPSS team resumed part of its community-based activities, in line with COVID-19 protective measures. Feelings of anxiety and depression related due to relational conflicts, gender-based violence exaggerated by COVID-19 related lockdowns, camp insecurity, community conflicts and lack of livelihoods, were some of the concerns identified. Some beneficiaries were identified as having moderate and acute signs of depression. Practicing religious activities (59%), seeking support from family (44%) and seeking medical care (37%), were the three most frequently reported coping and protective mechanisms (IOM 13/11/2020, IOM 24/11/2020).

Some reports have pointed to a rise in suicide attempts in the camps in Cox's Bazar since the onset of the COVID-19 pandemic, particularly among women. The data currently available on suicide is, however, difficult to read with certainty (UNHCR 12/11/2020).

The COVID-19 has impacted the mental health of children in the host community

COVID-19 has also had a detrimental impact on the mental health of many within the host community. The stress on families related to the loss of income, reduced access to schooling, and changes to children's behavior during quarantine contributes to an increase in the physical and emotional abuse of children. In Bangladesh, over 44% of the respondents experienced high levels of stress. This affects productivity, children's ability to learn, cohesion in the household and the health of the households. More than half of the respondent (58%) indicated that they were partially able, with one-third (33.7%) indicating capability while 7.2% respondent expressed that they cannot handle the situation (World Vision 07/07/2020).

Stressed parents and caregivers are now engaging in desperate negative behaviors towards their children with about 35% applying physical punishment or psychological aggression. Children felt isolated, distressed or worried during COVID, as 87% children reported feeling isolated while another 91.5% were worried about COVID 19 (World Vision 09/07/2020).

Reduction in provision of health services

COVID-19 constrained the provision of other health services including vaccinations, community outreach and access to health care services for pregnant women and people with long-term illnesses. Heavy rains and flooding added to the problem. COVID-19 has seen a decrease in parents and guardians getting the follow up shots in their vaccine schedule (WHO 28/10/2020). It has also caused drop in access to maternal, neonatal, child and adolescent health and nutrition, family planning and immunization services, threatening progress on maternal and new-born health indicators that were already stagnating before the pandemic (UNCT 16/09/2020). Additionally, as a result of the lockdown, TB activities were disrupted. Activities such as health education and community mobilization for TB awareness were scaled down or suspended (WHO 26/08/2020).

Health systems that were already overstressed due to COVID-19 pandemic had to deal with additional health issues and waterborne diseases as a result of heavy rain and flooding (IOM 31/07/2020).

Refugee Women and girls, as well as transgender persons and persons with disabilities, have less access to information in the camps, and face additional barriers in accessing some health services, due to the restrictive nature of social norms and social stigma. Some practices in health centers, particularly gaps in providing gender-segregated spaces and services, led to barriers in access for women and girls and transgender persons. Consultations have shown that men did not allow their female household members to stay in mixed isolation and treatment facilities with unknown men, while women and girls reported feeling unsafe in mixed facilities due to the risk of GBV and abuse, and families expressed unwillingness to separate (IOM 30/11/2020).

Fear of COVID is also impacting the level of care provided. A reduction in consultations as well as reluctance of health workers to treat patients with COVID-19 symptoms, fear of stigma, and rumors around COVID-19 were some of the issues that came up often during qualitative consultations with Rohingya refugees (IOM 31/07/2020). This is also an issue for host communities. Despite the order from the Government for all hospital authorities to ensure treatment for all patients, denial of healthcare, substandard quality and accessibility of services combined with stigmatization and discrimination continue to be reported as patients, including those with non-COVID-19 symptoms, claim to be refused treatment, some with deadly consequences (UNRC Bangladesh 02/07/2020).

Health and hygiene services for women and girls were disrupted

COVID-19 containment measures have disrupted health and hygiene services provided to women and girls in both the refugee and host communities. As all of the family members are confined at home together during the lockdown, there may be no private space for women to take care of their menstruation which can cause stress and anxiety (WaterAid 05/08/2020). Menstrual Hygiene Management (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 (CARE 14/10/2020).

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 [in terms of camp service provision] (CARE 14/10/2020).

Nutrition

Information sources, gaps and challenges

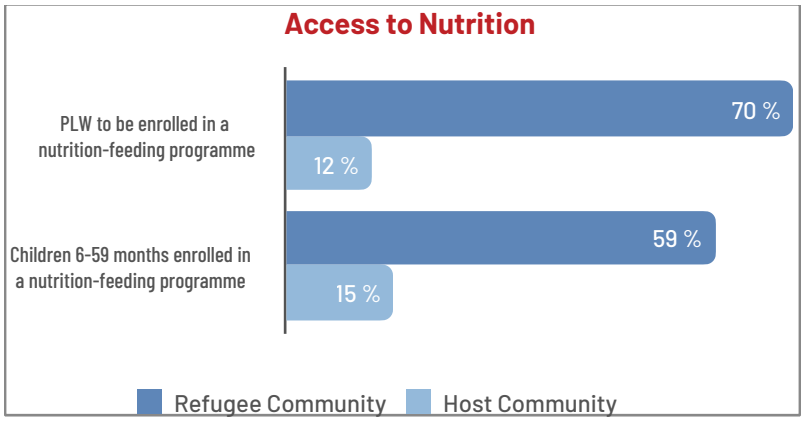
The majority of data for the nutrition section is derived from the detailed findings available in the J-MSNA, alongside the wider picture from the Immediate Socioeconomic Response to COVID-19 provided by the UNCT under the UNDAF. Whilst the J-MSNA released in November (with the data collected in July and August) gives some perspective on the post-COVID situation, more recent data would be preferable. Actual malnutrition rates for both refugee and host communities were not available. Action Against Hunger has conducted a COVID-19 modified round five SMART nutrition survey in refugee camps during November- December 2020. The findings from this assessment are yet to be published.

Enrollment in nutrition-feeding programs is high for Rohingya refugees but much lower for host communities

Seventy percent of the pregnant/lactating women of Rohingya refugees' households are reported to be enrolled in nutrition-feeding programs whereas the figure is much lower at 12% for pregnant/ lactating women of the host community. Fifty-seven of children aged 6-59 months in refugee households are enrolled in nutrition feeding programs, the figure for host community households is 15% (J-MSNA 12/11/2020, J-MSNA 12/11/2020).

The number of people receiving nutritional support is expected to be lower in the host community compared to the refugee camps since the host communities have only OTP and TSFP programs for malnourished children and PLWs (SAM+MAM), compared to the Rohingya refugees who benefit from OTP and TSFP programs for malnourished children and PLWs (SAM+MAM) as well as BSFP and GFD Programs. As different programming and targeting criteria are applied in the host community and refugee community, it is difficult to directly compare the nutrition enrollment rates (Nutrition Sector Input 20/12/2020).

Figure 12: Access to nutrition services for refugee and host communities



Source Compiled from: J-MSNA 12/11/2020, J-MSNA 12/11/2020

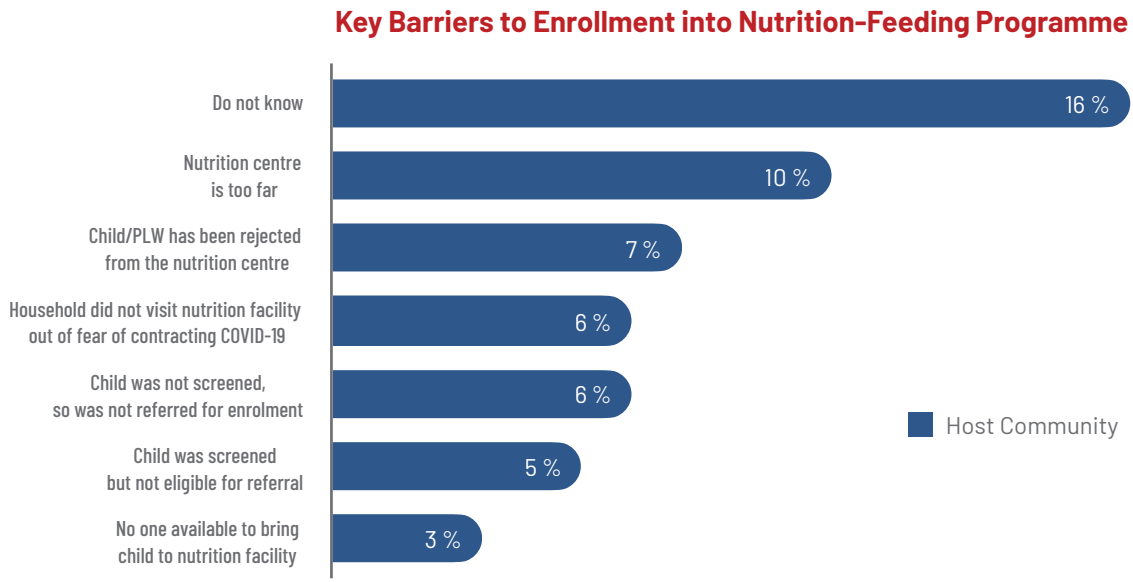
Enrollment rates amongst refugee households were found to differ significantly by the highest level of education of the head of the household. Households with no formal education were found to be significantly less likely to have enrolled children aged 6-59 months in a nutrition-feeding program, compared to households with primary education or greater (J-MSNA 12/11/2020).

Lack of access to nutrition programs is of particular concern for host communities. The COVID-crisis has resulted in massive disruption of livelihoods; the lack of access to basic services is causing millions to plunge into multidimensional poverty, food insecurity, malnutrition, jeopardizing the health and educational prospects of millions, with Cox's Bazar being one of the poorest and vulnerable districts in Bangladesh (UNCT 16/09/2020, ISCG 04/2020).

Barriers to nutrition programs are high in host communities

In line with low numbers reported enrolled in nutrition programs, more than half of the host community households (60%) reported facing issues enrolling children aged 6-59 months and pregnant and lactating women into nutrition-feeding programs. The top four issues reported were: nutrition center is too far (10% of respondents), child/PLW has been rejected from the nutrition center (7%), household did not visit nutrition facility out of fear of contracting COVID-19 on the way (6%) and child was not screened, so was not referred for enrolment (6%) (J-MSNA 12/11/2020).

Figure 13: Key barriers to Enrolment at Host community



Source: Compiled from J-MSNA 12/11/2020, J-MSNA 12/11/2020

Also (as expected with higher enrolment) the numbers reporting barriers to nutrition programs amongst the refugee community was much lower. Only 30% of the refugee households reporting to face the issues regarding enrollment, with the main issues being: nutrition center is too far (5% of respondents), long waiting times at nutrition facilities (5%) and household did not visit nutrition facility out of fear of contracting COVID-19 on the way (3%)(J-MSNA 12/11/2020).

The impact of COVID-19 on nutrition service provision

For the host community, the pandemic has further interrupted the availability and utilization of nutrition services that had not been widely available even before the lockdown. There was a dramatic decrease in the rates of inpatient and outpatient during April and May due to the fear of exposure, loss of income and reduced mobility (tying in with the "fear of contracting COVID-19" as a barrier to accessing nutrition services) (UNCT 16/09/2020, J-MSNA 18/10/2020).

Issues related to assistance/services was also investigated as part of the J-MSNA. Sixteen percent of households in the refugee community 16% of households reported nutrition assistance/services did not go well before the pandemic, this rose to 25% since COVID (J-MSNA 12/11/2020). This indicates a small but relevant rise in problems around nutrition provision. For the host community nutrition services were already more difficult to access and 28% of host community households reported nutrition assistance/services did not go well before the pandemic, this rose to 32% since COVID. It is possible the rise was much smaller for host communities as fewer households were enrolled in nutrition programs and so therefore fewer would have been affected (J-MSNA 12/11/2020).

COVID-19 could lead to increased malnutrition rates, particularly for children in the host community

The COVID-19 pandemic is disproportionately impacting the poorest and most vulnerable in Bangladesh. The extreme and moderate poor were hardest hit by the two-month-long general lockdown, suffering an average of 75% reduction in income which has had consequences in access to health care and nutrition (UNCT 16/09/2020). The deterioration in the food security situation due to COVID-19 containment measures and a further reduction in health services are likely to increase malnutrition rates especially for children under the age of five. Children in rural areas and from the poorest households are at increased risk of undernutrition due to the disruption in school feeding programs as a result of the closure of schools from the pandemic (Joint Hum INGO Statement 22/10/2020, UNCT 16/09/2020).

The declining quantity and quality of services as the impact of COVID-19 has exacerbated the already high prevalence of undernutrition in both the urban and rural areas of Bangladesh which are likely to cause immediate and long-term effects among the infants, young children, pregnant and lactating women. In addition to that, women, girls and female caretakers are vulnerable as they are likely to become more food insecure and have poorer nutritional indicators since they are facing the burden of increasing domestic and unpaid childcare work (UNCT 16/09/2020).

For the refugee community there are also concerns around nutrition and infant health. UNHCR cite the reduced uptake of preventive health services such as antenatal care and immunization; Poor infant and young child feeding and maternal care practices among children under 2 year; and that community-based psychosocial interventions are not yet at the scale needed to reach the number of refugees in need of these activities (UNHCR 09/11/2020).

Shelter

Information sources, gaps and challenges

Sources for information on the shelter situation were limited during the early period of the global pandemic as shelter partners were restricted from carrying out full-scale assessments due to COVID containment measures, but the situation has improved since the gradual restart of shelter assistance in Cox's Bazar. Some Quantitative data is found with the J-MSNA, alongside the prevalence of shelter needs. The July and September rounds of the COVID-19 NPM-IVR Needs Assessment provide more information around shelter issues. The Shelter Sector response updates and data is shared through the ISCG situation reports and sector 4w. The September protection factsheet from UNHCR gives a qualitative analysis on the relationship between refugee and host communities regarding shelter and land use.

Due to COVID-19 restrictions the Shelter Standards Survey planned for July - November 2020 will now be conducted in January 2021. The survey will be conducted with the support of NPM and REACH, in shelters across all camps, assessing them against the agreed Shelter Performance standards developed by the Shelter/NFI Sector to measure the impact of the previous and ongoing interventions, and inform the development of future shelter interventions.

Overcrowded camps present an increased risk for the spread of COVID-19

As outlined in the 2020 COVID-19 humanitarian response plan, 860,000 Rohingya refugees currently reside in 34 highly congested camps formally designated by the Government of Bangladesh in Ukhiya and Teknaf Upazilas of Cox's Bazar District; these refugee camps are among the most densely populated places on earth, and the overcrowding and unhygienic conditions increase the potential for the rapid spread of communicable diseases (IOM 22/07/2020).

Containment measures such as physical distancing and isolation due to COVID-19 could contribute to already existing structural problems such as overcrowding (the shelters are small and shared by an average of 5-6 family members) (IOM 31/07/2020).

Heavy flooding is exacerbating the cramped conditions within the camps and increasing the risk of COVID-19 transmission

A major increase in shelter damages were recorded during the current monsoon season. During June to 30 August, 1,236 shelters were partially damaged, and 1,854 shelters were totally damaged, affecting 25,631 households across all 34 camps. This is an increase of 100% when compared to the same period in 2019. The situation was compounded by COVID-19 restrictions which have negatively impacted monsoon preparedness activities and shelter programming. Seventy-three percent of respondents to an IOM survey reported not receiving a shelter kit before monsoon season. Another aggravating factor is continued use of lightweight and temporary materials (IOM 20/09/2020, Shelter Sector Input 14/12/2020).

The majority of households had issues with their shelter but not all were able to effect repairs due to a shift in COVID-19 response priority focusing only on critical services.

With the temporary nature of many of the shelter solutions along with congestion, poor site typography and often destructive climatic events (such as windstorms, heavy rains, slope failure, landslides, and flooding), many households (both refugee and host community) need to effect repairs to their shelters. The most sought assistance through the response-wide Community Feedback and Response Mechanism has been shelter-related assistance, with more than 18,000 referrals made between March and September 2020 (ACAPS 20/08/2020, SMSD 05/09/2020). The move to critical activities only, as part of the COVID-19 response, has reduced access for regular repair and maintenance in the camps, with the consequence that more intensive repair and rebuilding of infrastructure will likely be necessary following the monsoon season (IOM 20/09/2020).

Sixty-nine percent of refugee households reported having issues with their shelter during the 6 months prior to data collection, with the biggest issue being the roof (mentioned by 51% of the households). Unsurprisingly, for those that made improvements the most common improvement was repair/upgrade of the roof (37% of households). Where no improvements were made, 46% of households stated that there was no need for improvement. Barriers to making improvement included: Did not receive any support from humanitarian organizations (36% of households); no money to pay for materials (23%) and could not access materials (15%) (J-MSNA 12/11/2020).

For host communities 59% of households reported issues with their shelter during the 6 months prior to data collection, with the biggest issue being the roof (mentioned by 46% of the households). Again, for those that made improvements the most common improvement was repair/upgrade of the roof (28% of households). Where no improvements were made, 58% of households stated that there was no need for improvement. Barriers to making shelter improvements for the host communities included: no money to pay for materials (39%); no money to pay for labor (9%) and could not access materials (8%) (J-MSNA 12/11/2020).

Rising tensions with the host community could be impacting on shelter condition of refugees

Tensions and insecurity may also arise as the Rohingya refugees and humanitarians may be blamed for the spread of the virus because of the unhygienic and overcrowded conditions in the camps. An increase in hate speech, racism and stigmatization is already evident in local reporting and social media, and in the rise in crime and attacks (IOM, 22/07/2020).

In several camps, relations between refugees and host communities have deteriorated in the first half of 2020. Some of the incidents reported include arbitrary increase in rents for land on which refugees have built shelters, threats and harassment of refugees to forcibly vacate the land they occupy, physical violence, robbery and extortion (UNHCR 19/10/2020).

Based on the J-MSNA 10% of households reported having had to make rent payments to live in their current shelter in the 6 months prior to data collection (the majority of whom were located in Teknaf). However only 1% of households reported having been involved in land or shelter related disputes with the host community in the 6 months prior to data collection (J-MSNA 12/11/2020). In October, shelter partners were reporting increased need for Housing, Land and Property (HLP) activities, including conflict mediation and assistance to identify land for refugees facing eviction (ISCG 12/03/2020).

Response Capacity: Shelter Sector partners have developed communication materials to guide safe delivery of Shelter/NFI assistance and protect volunteers, staff and vulnerable older people considered to have high risk of COVID-19

In response to lack of information and fear from the partner staff and beneficiaries about COVID-19 during the earlier phase of the lockdown, the Shelter/NFI Sector developed

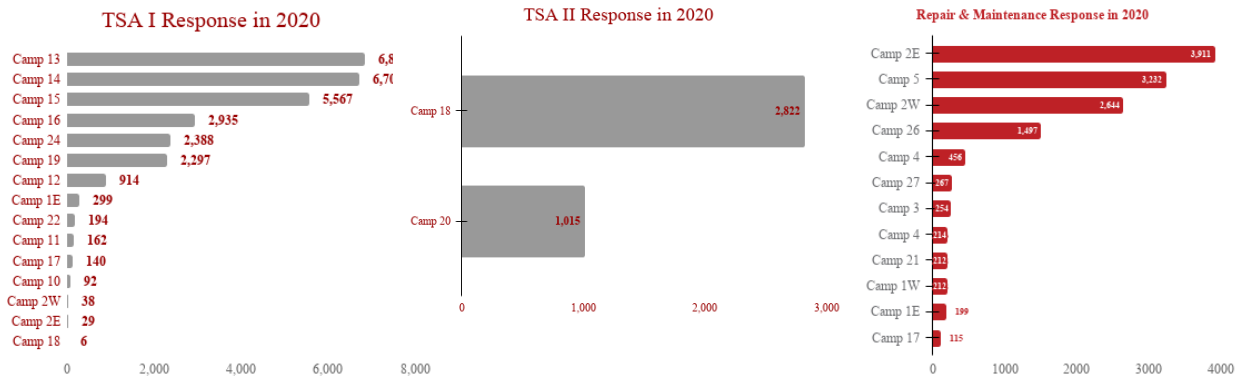
communication materials which were shared with staff members, volunteers and beneficiaries to provide specific guidance for shelter assistance in light of COVID-19, particularly on how to disinfect the materials and keep hygiene precautions, as well as how to provide safe distribution of assistance to families and ensuring construction site safety (Shelter/NFI Sector 04/06/2020, 04/26/2020, 05/14/2020, 05/29/2020, 06/14/2020).

Response Capacity: The easing of lockdown measures has allowed shelter partners to provide urgent shelter assistance, yet on-site shelter needs assessment is still limited due to COVID-19 restrictions

The revised directive from the government (RRRC) in August allowed humanitarian access and the subsequent restart of three regular shelter programmes: Transitional Shelter Assistance Phase I (TSA I), Mid Term Shelter (MTS) and Repair and Maintenance (RM); and the commencement of the new Transitional Shelter Assistance Phase II (TSA II), to support the most vulnerable shelters till the end of 2020.

In October and November: 2,916 households received TSA I, 4,540 households received TSA II, 72 new MTS were constructed, 7366 households received RM support. By the end of November, a total of 33,412 households were assisted with emergency shelter support. Most shelters were partially and fully damaged; roofs and/or walls were blown away or had severe damage, and structural bamboo posts and/or beams were damaged or missing. The households were provided with shelter repair kits including bamboo, tarpaulins, rope and jute bags. Households with special shelter needs (PwSN) were provided with materials delivery/ portering and construction assistance (Shelter Sector Input 20/12/2020).

Figure 14: Repair & Maintenance Activities implemented in 2020



Source: SNFI Tracker, 31/10/2020

The emergency shelter response partners were successful in assessing/verifying the damages within 72 hours with 100% response/assistance rate. Shelter needs are currently identified through a desktop exercise since door to door assessment is not advised due to the COVID-19 situation. Transitional Shelter Assistance Phase II (TSA II) assistance is following the COVID containment standards by minimizing contact with the beneficiaries while ensuring

appropriate assistance. Information from the sector shows that over 13,200 shelter repair and maintenance activities have been completed in November 2020 (SNFI Tracker, 31/10/2020).

About this report

IMMAP and DFS currently implement the OFDA COVID-19 support project in six countries: Bangladesh, Burkina Faso, Nigeria, DRC, Syria, and Colombia. The project duration is twelve months and aims at strengthening assessment and analysis capacities in countries affected by humanitarian crises and the COVID-19 pandemic. The project's main deliverables are a monthly country-level situation analysis, including an analysis of main concerns, unmet needs, and information gaps within and across humanitarian sectors.

The first phase of the project (August-November 2020) focuses on building a comprehensive repository of available secondary data in the DEEP platform, building country networks, and providing a regular analysis of unmet needs and the operational environment which humanitarian actors operate. As the repository builds up, the analysis provided each month will become more complete and robust.

Methodology: To guide data collation and analysis, IMMAP and DFS designed a comprehensive Analytical Framework to address specific strategic information needs of UN agencies, INGOs, LNGOs, clusters, and HCTs at the country level. It is essentially a methodological toolbox used by IMMAP/DFS Analysts and Information Management Officers during the monthly analysis cycle. The Analytical Framework:

- Provides with the entire suite of tools required to develop and derive quality and credible situation analysis;
- Integrates the best practices and analytical standards developed in recent years for humanitarian analysis;
- Offers end-users with an audit trail on the amount of evidence available, how data was processed, and conclusions reached;

The two most important tools used throughout the process are the Secondary Data Analysis Framework (SDAF) and the Analysis Workflow.

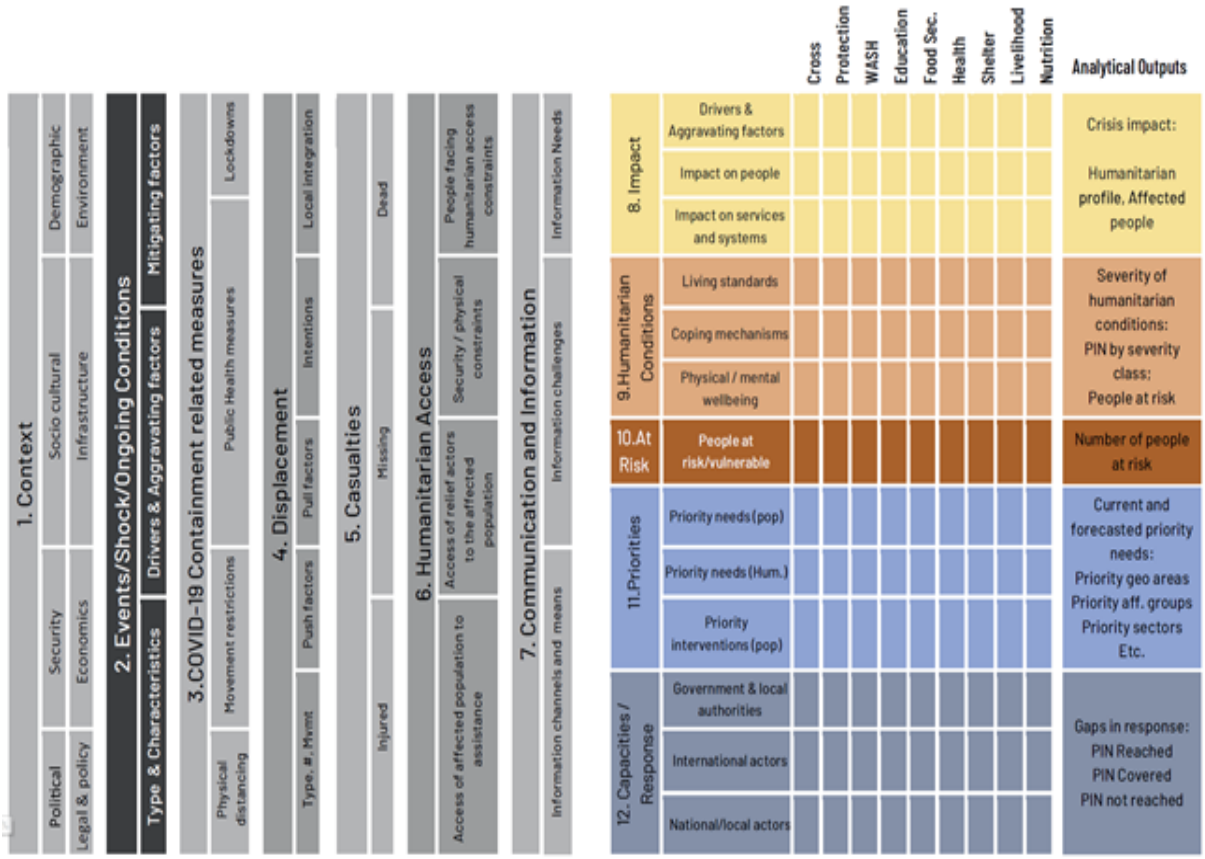
The Secondary Data Analysis Framework was designed to be compatible with other needs assessment frameworks currently in use in humanitarian crises (Colombia, Nigeria, Bangladesh) or developed at the global level (JIAF, GIMAC, MIRA). It focuses on assessing critical dimensions of a humanitarian crisis and facilitates an understanding of both unmet needs, their consequences, and the overall context within which humanitarian needs have developed, and humanitarian actors are intervening. A graphic representation of the SDAF is available in figure 15.

On a daily basis, IMMAP/DFS Analysts and Information Management Officers collate and structure available information in the DEEP Platform. Each piece of information is tagged

based on the pillars and sub-pillars of the SDAF. In addition, all the captured information receives additional tags, allowing to break down further results based on different categories of interest, as follows:

1. Source publisher and author(s) of the information;
2. Date of publication/data collection of the information and URL (if available);
3. Pillar/sub-pillar of the analysis framework the information belongs to;
4. Sector/sub-sectors the information relates to;
5. Exact location or geographical area the information refers to;
6. Affected group the information relates to (based on the country humanitarian profile, e.g., IDPs, returnees, migrants, etc.);
7. Demographic group the information relates to;
8. The group with specific needs the information relates to, e.g., female-headed household, people with disabilities, people with chronic diseases, LGBTI, etc.;
9. Reliability rating of the source of information;
10. Severity rating of humanitarian conditions reported;
11. Confidentiality level (protected/unprotected)

Figure 15. IMMAP/DFS Secondary Data Analysis Framework (SDAF)



The DEEP structured and searchable information repository forms the basis of the monthly analysis. Details of the information captured for the Bangladesh Cox's Bazar report are available below (publicly available documents primarily from 23 October to 30 November were used).

Figure 16: Documents by location, timeline, and primary categories (analytical framework)

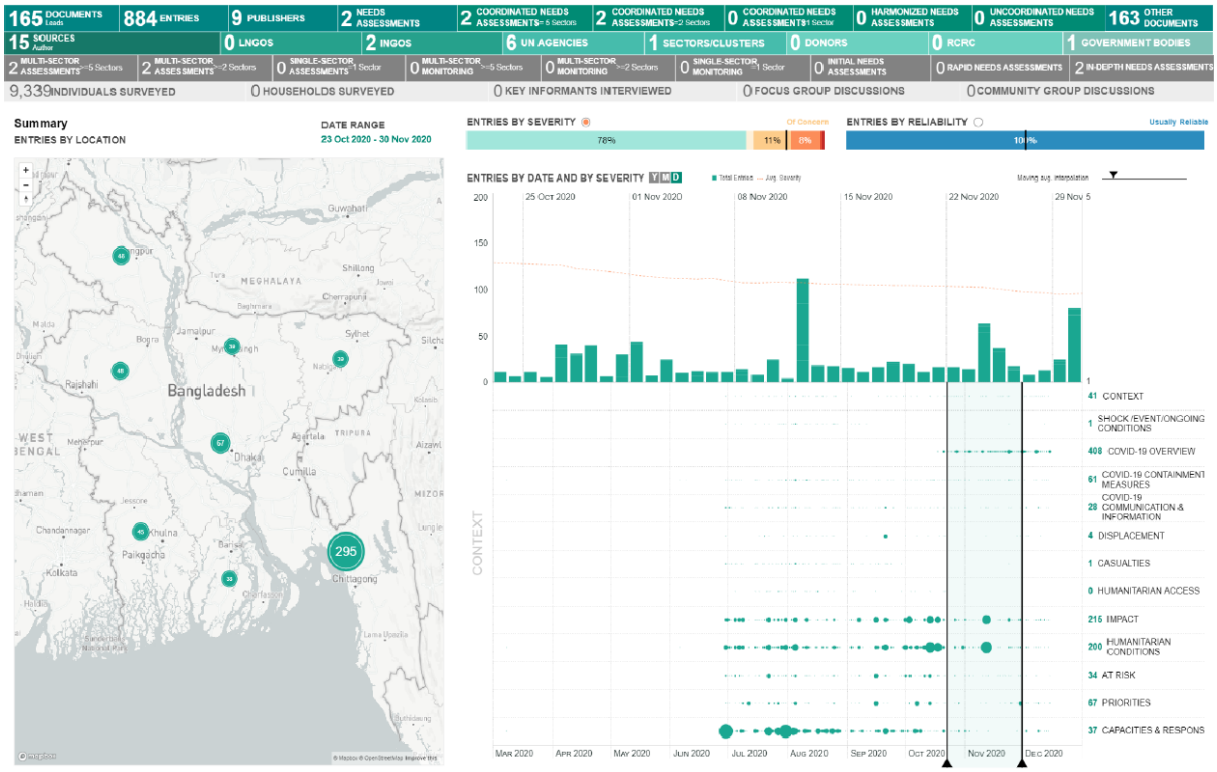


Figure 17: Documents and entries by sector and affected group

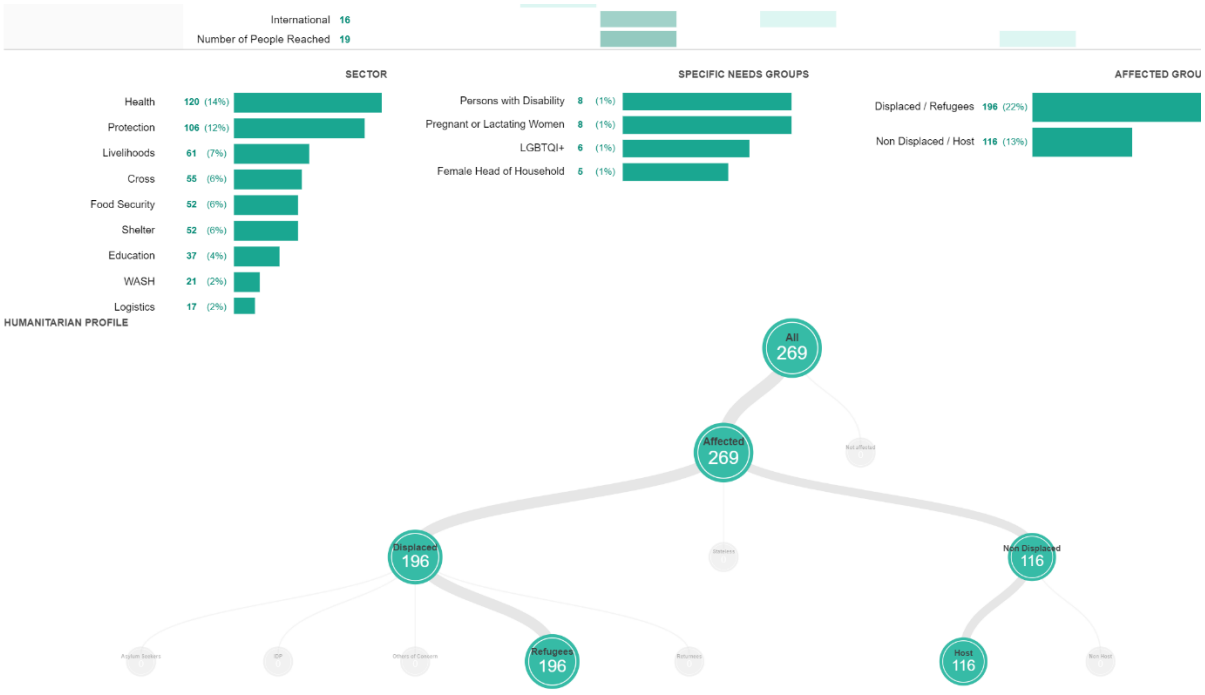
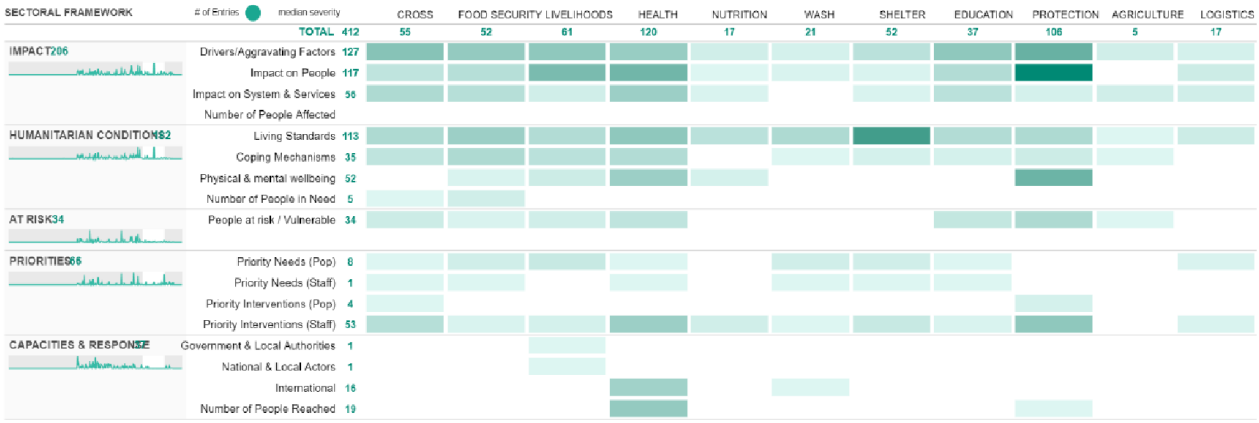


Figure 18: Entries by sector and sub-categories (analytical framework)



Analysis Workflow IMMAP/DFS analysis workflow builds on a series of activities and analytical questions specifically tailored to mitigate the impact and influence of cognitive biases on the quality of the conclusions. The IMMAP/DFS workflow includes 50 steps. As the project is kicking off, it is acknowledged that the implementation of all the steps will be progressive. For this round of analysis, several structured analytical techniques were implemented throughout the process to ensure quality results.

- The ACAPS Analysis Canvas was used to design and plan for the September product. The Canvas support Analysts in tailoring their analytical approach and products to specific information needs, research questions or information needs.

- The Analysis Framework was piloted, and definitions and instructions set to guide the selection of relevant information as well as the accuracy of the tagging. A review workshop was organized in October 2020 to review pillars and sub pillars.

- An adapted interpretation sheet was designed to process the available information for each SDAF's pillar and sub pillar in a systematic and transparent way. The Interpretation sheet is a tool designed so IMMAP/DFS analysts can bring all the available evidence on a particular topic together, judge the amount and quality of data available and derive analytical judgments and main findings in a transparent and auditable way.

- Information gaps and limitations (either in the data or the analysis) were identified. Strategies have been designed to address those gaps in the next round of analysis.

The analysis workflow is provided overleaf (Figure 19).

Figure 19. IMMAP/DFS Analysis Workflow

IMMAP/DFS Analysis Workflow					
	1.Design & Planning	**2.Data collation & collection**	**3.Exploration & Preparation of Data**	**4.Analysis & Sense Making**	**Sharing & Learning**
Main activities	Definitions of audience, objectives and scope of the analysis	Identification of relevant documents (articles, reports)	Categorization of the available secondary data	Description (summary of evidence by pillar / sub pillar of the framework)	Report drafting, charting and mapping
	Key questions to be answered, analysis context, Analysis Framework	Identification of relevant needs assessments	Assessment registry	Explanations (Identification of contributing factors)	Editing and graphic design
	Definition of collaboration needs, confidentiality and sharing agreements	Data protection & safety measures, storage	Additional tags	Interpretation (priority setting, uncertainty, analytical writing)	Dissemination and sharing
	Agreement on end product(s), mock-up and templates, dissemination of products	Interviews with key stakeholders	Information gaps identification	Information gaps & limitations	Lessons learnt workshop, recommendations for next round
Tools	• Analysis Framework • Analysis Canvas • Data sharing agreements • Report template	• SDR folder • Naming convention	• DEEP (SDAF) • DEEP (Assessment registry) • Coding scheme	• Interpretation sheet	• Revised report template • Analytical writing guidance • Lessons learnt template

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