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COVID-19 IMPACT ON CHILDREN

COVID-19 SITUATION ANALYSIS

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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 March 11th, 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 timely solutions to the growing global needs for assessment and analysis among humanitarian stakeholders.

iMMAP, in collaboration with the Data Friendly Space (DFS), are working together to generate a comprehensive secondary data review of the reports, assessments, research papers available at the field level to provide humanitarian actors with a thorough analysis of the impact of the COVID-19 pandemic and providing lessons learned for improving humanitarian programming.

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Child Protection Sub-Sector coordination team

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EXECUTIVE SUMMARY

The spread of COVID-19 and the related containment and risk mitigation measures have had a negative impact on children in Cox's Bazar, both among the host and refugee communities. The overall reduction in humanitarian footprint in the camps meant many protection services were suspended or scaled back, child friendly spaces (CFS), multi-purpose centres (MPC) and adolescent friendly spaces (AFS) closed, and psychosocial support systems limited. The reduced humanitarian footprint has also made it more difficult to reach children to inform them about COVID-19 and the associated risks. Additionally, children facing child protection risks have fewer available avenues to seek support or report such incidents.

The closure of schools and learning centers and the loss of livelihoods have been some of the main drivers that have heightened protection risks such as child labour, early marriage, domestic violence, and risks of trafficking. While these risks have existed within the communities before the pandemic, they have increased throughout 2020. However, the scale of these issues is difficult to measure as they are often underreported, there are limited available protection services, and the ability to record such incidents is also limited. It is likely that such protection risks will continue to be a concern in 2021, especially with the current lockdown measures. During periods of lockdown, when schools, learning centers, and other child-based facilities (CFS, MPC, AFS) have been closed, children have felt isolated, distressed and have had limited access to support services.

Among the host community, children in poor households are at risk of undernutrition due to the disruption of school feeding programs as a result of the school closures. Poor households from both communities had to cut down their nutritional intake and reduce their daily expenditure to cope with the financial constraints resulting from the pandemic, and there has been a noticeable increase in the percentage of households adopting consumption-based coping strategies. Children under five were among the most vulnerable groups affected by reduced food stocks in homes as families adopt mitigation measures to cope with reduced income in households.

Children in the Rohingya refugee camps struggled to access education even before the pandemic, but as students were forced to move to distance or caregiver-led learning, the refugee community were at a disadvantage. Educational institutions act as a protection mechanism and the fact that children are forced to stay home increases protection risks, such as violence in the home. Children are also less able to receive adequate supervision, which increases risks of dangers and injuries and exposes them to neglect, risks of trafficking, and/or child labour. For the host community, financial constraints remain the main barrier to accessing remote learning.

CONTEXT

Socio Economic Situation in Bangladesh

Bangladesh has made great strides in socio-economic development over the last few decades. One of the most notable indicators of this is a rapid reduction in the mortality of children under five years of age. This coupled with the success of the country's family planning programme has also resulted in a rapid and consistent reduction in fertility rate, from 6.3 in 1975 to 2.3 in 2019 (UNICEF 05/2021). This is only slightly higher than the standard replacement rate of 2.1.

Joint research carried out by the South Asian Network on Economic Modeling (SANEM) and ActionAid Bangladesh indicates that during COVID-19 in 2020, household incomes decreased by 70%. Another survey by SANEM in November and December 2020 found that approximately 42% of the 5,577 households surveyed dropped below the poverty line due to the pandemic. The government's Report on SDG's in June 2020 showed that the COVID-19 pandemic decreased employment opportunities for the poorest, setting back progress in reducing the national poverty rate, which had fallen from 40% to 20.5% between 2005 to 2019. Whereas the poverty rate has increased to 29.5% in 2020. COVID-19 induced job loss in urban areas triggered mass migration back to rural communities. This large urban-to-rural movement not only posed a health risk to the villages that people returned to, but also caused additional strain on their families' meagre income (World Vision 07/07/2020).

The pandemic unsettled Bangladesh's decades-long macro-economic stability. Government-imposed movement restrictions disrupted economic activities. Bangladesh now faces fiscal risks, including a shortfall in international support for COVID-19 vaccination programs, cost overruns on major infrastructure projects, and delays in tax reform. There have also been challenges in implementing credit and social protection programs under the government's economic stimulus program, which could undermine national economic recovery efforts. Other external risks stemming from the fragile global economic recovery have resulted in weak demand for ready-made garments (RMG) and reduced employment of Bangladesh's overseas workforce. However, low public debt levels and low risk of public debt distress have provided some buffer for Bangladesh (World Bank 12/04/2021).

Children, especially those suffering from poverty and inequity, are among the most vulnerable to the harsh socio-economic impacts of COVID-19. Even when excluding pre-existing high rates of child malnutrition, physical abuse, psychological and emotional abuse, neglect and inadequate access to proper sanitation, the vulnerability of children and their families has been grossly aggravated by COVID 19 and the consequences of containment and risk mitigation measures. In Bangladesh, where almost 45 million children are predominantly subjected to violent discipline, including gender-based violence, reports increased by an estimated 31% during the pandemic (UNICEF 16/12/2020). Across Bangladesh, children now face greater risk of severe hunger, disease, early marriage, child labour and physical and psychosocial health risks (World Vision 07/07/2020). Increased poverty is projected to create an additional barrier to children's rights and children from vulnerable households, including those with no wage earners, reported lower levels of access to alternative learning modalities.

School closure, which is one of the containment measures for the reducing transmission of COVID-19, could have future socioeconomic consequences for Bangladesh. UNICEF projections suggest that 620,000 children are expected to permanently drop out of school, of which 350,000 are expected to be girls. Given the sociocultural context in Bangladesh and considering the economic hardship many families have recently faced due to the pandemic, many of these girls could face the risk of child marriage, child labour, and adolescent pregnancy (UNICEF 03/2021).

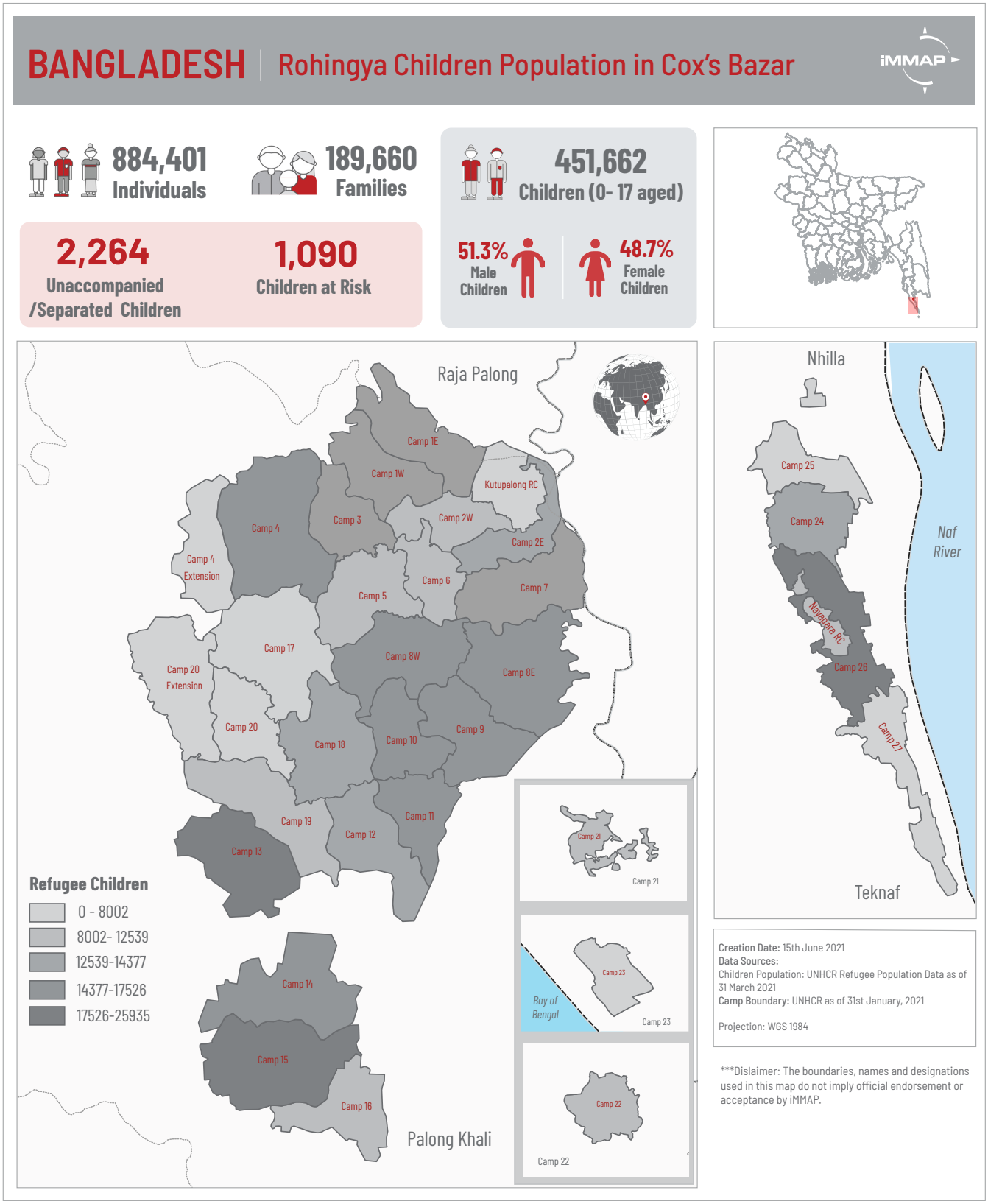
Loss of livelihoods is the primary concern for the rural and urban poor and directly impacts on the ability of parents and caregivers to provide for children's well-being, including access to food and nutrition, access to healthcare and essential medicines, access to hygiene and sanitation facilities, and child protection and safety (World Vision 07/07/2020). Children dropping out of school will also have an impact on future economic attainment and education of future generations. A recent simulation by the World Bank quantified the loss of learning in terms of labour market returns and indicated that the average Bangladeshi student will face a reduction in annual earnings of between USD 198 to USD 335 once they enter the labour market, which represents between a 4% and 6.8% drop in annual income. In the intermediate scenario, aggregating for all students, this would cost the Bangladeshi economy USD 89 billion in Gross Domestic Product (GDP) annually.

Socio Economic Situation in Cox's Bazar

Cox's Bazar district is one of the most underdeveloped districts in Bangladesh. Situated in the south of the country, it is in a disaster prone "cyclone belt" (WFP 10/05/2021). Even before the pandemic and the 2017 Rohingya refugee influx, Cox's Bazar district had a high level of poverty and among the lowest development indicators in the country (UNICEF 13/08/2020). According to the Bangladesh Bureau of Statistics, Cox's Bazar is one of the lowest-performing districts in Bangladesh in terms of education and skills training, with about 33% of the population living below the poverty line (IOM 26/02/2021). The COVID-19 pandemic hit the local economy hard, with 51% of the host community population reported as moderately or highly vulnerable in 2020, up from 41% in 2019. This increase in vulnerability could be attributed to the COVID-19 containment and risk mitigation measures which resulted in a decline in economic activity, especially in the informal sector which absorbs most of the host community labour force (WFP 10/05/2021). COVID-19 has resulted in 700,000 people losing their income since the outbreak of the pandemic in mid-March 2020 (IOM 26/02/2021). Pandemic-related economic effects threaten to undermine years of steady progress in poverty reduction in Bangladesh and recent economic growth in Cox's Bazar (World Bank 12/04/2021). COVID-19 has also intensified the needs of Rohingya refugees.

Demography

Figure 1. Rohingya children population at Cox's Bazar (Source: UNHCR)



Information and Communication

Information Channels and Means

In Cox's Bazar district, Government of Bangladesh, humanitarian agencies and their partners continue to raise awareness about COVID-19 through targeted sessions, door-to-door visits, radio listening sessions, and video awareness sessions with communities throughout the camps. Messaging has been focused on COVID-19 prevention measures, testing, quarantine and isolation facilities, and child protection (IOM 29/10/2020). Leaflets were also distributed to raise awareness on risks and COVID-19 prevention, targeting children and caregivers. Child protection actors also published a booklet for Rohingya adults and adolescents entitled, 'Heart-to-Heart with My Child', and a Rohingya audio version of the children's book 'My Hero is You'. These were distributed to beneficiaries through child protection partners to convey key child protection messages associated with the pandemic (UNHCR, 02/06/2020; ISCG 01/11/2020). However, age-appropriate and understandable data on COVID-19 available for Rohingya children remains lacking and information about the accessibility of the few materials available for children is also lacking. Other child-friendly COVID-19 materials were published by the Child Protection Sub-Sector (CPSS) and their partners to raise awareness on COVID-19, but reaching the most vulnerable children with these materials remained a challenge. The closure of child protection facilities and education centres due to containment and risk mitigation measures makes it more difficult to reach children (CPSS 17/09/2020).

In the host community, humanitarian agencies distributed booklets in Bangla of "My Hero is You", focused on COVID-19 awareness for children living in Ukhiya and Teknaf (ISCG 01/11/2020) along with other COVID-19 materials translated into Bangla and aimed at children in host communities. Adolescents living in urban areas were found to have more precise knowledge about COVID-19 compared to their rural counterparts, with slightly more access to diverse sources of information such as the internet (e.g. websites and YouTube channels), social media (e.g. Facebook), television (e.g. news reports and advertisements), school teachers, family members, and awareness-raising campaigns in the locality (gage 04/2021).

Information Challenges/Barriers

Language and access to communication channels like mobile phones, sim cards, and internet has been one of the main barriers to accessing information for the Rohingya population (TNH 25/06/2020, ISCG 18/10/2020). Since the refugee influx in 2017, language has continued to be a serious communication barrier between aid workers and Rohingya refugees, especially with illiterate households (UNICEF 02/07/2020). Despite the fact that multiple languages are spoken in the refugee camps, only a minority of Rohingya households speak Burmese, Bangla, Chittagonian, or English (ISCG 12/11/2020). Rohingya remains the spoken language that refugees understand and prefer (UNICEF 02/07/2020). In the host community, no significant language barriers were reported. However, while 97% of households reported having enough information on COVID-19 precautionary measures, this dropped to 86% for points of contact and 82% for enough information on symptoms and vulnerable groups (J-MSNA 2020).

Poor connectivity negatively affects information flow in the camps (ISCG 18/10/2020). Although the ban on 3G and 4G internet connectivity was lifted on 28 August 2020 (Dhaka Tribune 29/08/2020), refugees still cannot afford adequate internet and telecommunication access (UNHCR 15/06/2020). In the host community, there are no significant barriers to accessing mobile connectivity other than that many do not own a mobile phone. Poor mobile connection prevents people from receiving information as well as reporting problems (J-MSNA 2020).

According to the Child Protection Sub Sector, the information that is available to the general population is not age-appropriate and understandable, especially for younger children. With child protection facilities and education centres now closed, it is also more difficult to reach children. As a result, children are struggling to access the information on COVID-19 they need.

SECTORAL ANALYSIS

INFORMATION GAPS

COVID-19 containment and risk mitigation measures in 2020 (ongoing at the time of writing, in 2021) led to a dramatic reduction in the humanitarian footprint, especially in protection and child protection more specifically. In 2020, only critical services were permitted. For the CPSS, this was limited to 50% of case management actors. CPSS relied heavily on volunteers and community based child protection mechanisms to provide essential services and scaled up remote support. With schools still closed, there is limited data on how COVID-19 has impacted children, for example in terms of nutrition and the halting of school feeding programs.

CHILD PROTECTION

Pre-COVID-19

Even prior to the pandemic, a combination of factors (displacement, overcrowding, insufficient lighting, violence, and temporary shelter construction) left Rohingya children feeling unsafe and afraid of getting lost, harassed, trafficked or kidnapped (JRP 2020, SCI, PI, WVB 24/02/2018). Cultural traditions also put girls at risk of early marriage or purdah.[1] Girls often reported being afraid to access WASH facilities due to daily harassment and risk of violence and/or sexual assault (JRP 2020, ACAPS 11/03/2019, SCI, PI, WVB 24/02/2018). Consequently, parents often preferred to keep their children inside, particularly girls, impacting their ability to access education services (CPSS Partners 24/10/2019).

Overcrowding in the camps makes it hard for adolescent girls (aged 12 and above, as understood by the Rohingya) to practice purdah, increasing their risk of harassment and assault. In order to protect their daughters or reduce economic burdens on the household, families would marry them off young (JRP 2020). Child marriage is considered to be common practice among many Rohingya households (JRP 2020, ISCG 03/12/2017, Melnikas et al. 25/05/2020), but the rate of child marriage in the camps is difficult to estimate (IPA, Yale, and Gage 01/12/2019).

Due to poverty and lack of employment opportunities, there was already a high prevalence of organized crime pre-COVID-19, with anecdotal reports of kidnapping and attempted kidnapping and the presence of human traffickers in the camps (CPSS Partners 24/10/2019). Rohingya girls were reported to be more vulnerable to sex trafficking, while boys and girls were both forced into child labour (UNICEF, UNFPA, UN Women 07/2019). Despite anecdotal evidence, the scale of these issues is difficult to measure as they are considered sensitive and are often underreported.

In the host community, household poverty and limited alternative livelihood opportunities for adults resulted in children being pulled out of education to engage in child labour. Both Ukhiya and Teknaf had high incidences of child labour even prior to the 2017 influx – between 7% and 9% respectively – compared to the national average of 6% (District Statistics 2011). This rendered children vulnerable to kidnapping and trafficking for sexual exploitation or drug transportation, and to other protection risks (USAID 08/10/2018). Since the refugee influx in 2017, roads and other public places have been viewed as dangerous as the increase in volume of traffic created road hazards that made movement for children and adolescents unsafe (UNDP 01/11/2018). Newly crowded locations also led to the perception of a rise in risk of kidnapping (IRC 28/02/2019, IPA, Yale, and Gage 01/04/2020).

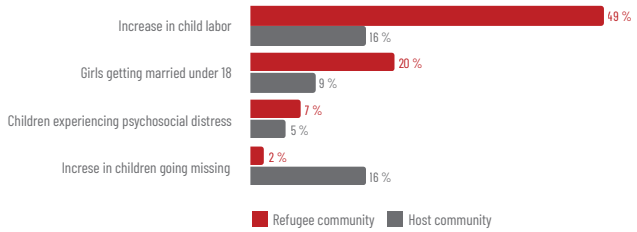
During COVID-19

Increase in protection issues such as child labour, child marriage, child trafficking, and abuse/violence since the onset of the COVID-19 pandemic and the subsequent lockdowns

Assessments conducted since mid-2020 show an increase in protection issues such as child labour, child marriage, risks of child trafficking, and cases of abuse/violence since the onset of the COVID-19 pandemic. Some of the main reasons for this increase in the Rohingya community remain the school closures and other child-based or educational facilities as well as, and financial pressure faced by families (J-MSNA 2020, CPSS 27/01/2021, CPSS 17/09/2020, ISCG, Care, Oxfam, UN Women, and ACAPS 14/10/2020, IRC 01/2021). There has also been an increase in household tensions, putting children and adolescents at greater risk of abuse, neglect, and violence (ISCG, Care, Oxfam, UN Women, and ACAPS 14/10/2020).

1. Purdah is the seclusion of girls and women after puberty. This practice represents a "sign of religious achievement" for women, as well as signifying family pride and status more broadly, and is closely linked with the religious and social significance of marriage and women's ascribed gender roles within the household (Child Protection Sub Sector Partners 24/10/2019).

Figure 2. Children Exposure to protection risk
(Sources: J-MSNA 2020_HC, J-MSNA 2020_RC)



According to the 2020 J-MSNA,[2] child labour among the Rohingya has increased by 16% and the marriage of girls under 18 by 9%. The increasing rate in forced and child marriage is attributed to increased financial pressure faced by families as well as the desire to keep girls safe. Dowry payment for early marriage was found to be a negative coping mechanism in the face of financial hardships (BBC Media Action 20/12/2020, BBC 14/01/2021, PWG 21/12/2020). Child marriage is likely to lead to domestic violence and to girls dropping out of school (UNICEF 08/03/2021). These risks are exacerbated by limited access to services due to mobility restrictions and cultural factors. In addition, 5% of households in the refugee community reported an increase in violence against children or children experiencing psychosocial distress (J-MSNA 2020). Because data collection for the J-MSNA was conducted primarily by phone, these results cannot represent the whole picture. Phone ownership is generally held by men and phone calls lack guarantee of privacy for candid conversations. In reality, the figures are likely to be much higher than are reflected in the J-MSNA findings. Additionally, due to reduction in humanitarian footprint and closure of facilities, there were far fewer avenues for children to report violence, including violence in the home.

In mid-2020, in both the host and refugee communities, kidnapping was reported as one of the main fears parents had for their children. Residents in Teknaf reported minimizing their children's movement to protect them from kidnapping (ISCG, Care, Oxfam, UN Women, and ACAP 14/10/2020, ACAPS 28/04/2021)

Child protection services scaled back to reduce the spread of COVID-19

The overall reduction in humanitarian footprint as a result of containment and risk mitigation measures to prevent the spread of COVID-19 has compounded protection issues. Many protection services were suspended or scaled back, child friendly spaces closed, and psychosocial support systems halted, causing indirect adverse impacts on vulnerable children who are now facing heightened protection risks. Only case management for children was considered a critical service and permitted to continue in the camps, but was also scaled back by around 50% (Child Protection Sub-Sector).

As of April 2021, Cox's Bazar district has been under new lockdown measures (RRRC 05/04/2021). Similar secondary impacts as the first lockdown are expected as child protection services have again been limited to prevent the spread of COVID-19 (J-MSNA 2020, CPSS 27/01/2021, CPSS 17/09/2020, ACAPS 30/05/2021).

Increase in protection issues among children in the host community such as child marriage, child labour, and violence

The 2020 J-MSNA, in the host community found that almost half of all households surveyed (49%) reported that child labour had increased in their communities in the six months prior to data collection. A high prevalence of child labour was reported in both Ukhiya and Teknaf (J-MSNA 2020). This is in line with national trends; as families lose livelihood opportunities more children become involved in income generating activities, such as becoming garment workers, bus helpers, and day labourers (BBC Media Action 20/12/2020). A further 20% reported an increase in girls under 18 getting married, and 2% reported an increase in violence against children and/or children going missing. The actual rates of child marriage, labour and violence are likely much higher, but tend to be under reported due to limited available protection and gender-based violence (GBV) services and the ability of children to report such incidents.

Data from January to December 2020 shows a high number of GBV incidents were reported in Cox's Bazar district, with most of the cases reported as intimate partner violence (IPV). IPV accounted for 82% of GBV cases in 2020 and 79.2% in 2019. Most of these cases occurred domestically (survivors' residence and perpetrator's residence), meaning that children are very likely to witness violence in the home (WASH sector, Humanitarian Response 01/04/2021).

Among the host community forced and child marriage was one of the top concerns for girls during the lockdown period in 2020 (ISCG, Care, Oxfam, UN Women and ACAPS 14/10/2020). Community feedback from across the country shows that parents are unsure when schools will reopen and are expressing concerns about their daughters'

2. Data collected between July and August 2020. It is worth noting the limitations of the J-MNSA methodology in COVID-19 context leading to probable under-reporting of child marriage, violence against children and other serious child protection concerns in 2020.

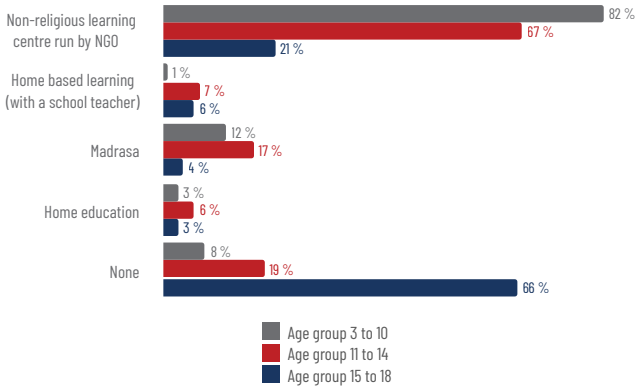
attitudes towards relationships with boys. They are thus marrying off their daughters, especially as income loss puts a financial strain on the household (BBC Media Action 20/12/2020).

EDUCATION

Pre-COVID-19

Prior to the outbreak of COVID-19, 694,000 Rohingya children and youth were reported to be in need of education support (JRP 2019). Rohingya children's lack of status has a serious impact on their access to education as they cannot access formal education. As a result, Rohingya children are not permitted to enrol in public education institutions. Even where they can access informal education, they are not allowed to obtain certification or formal qualifications (Save the Children 06/2021). The Rohingya are thus reliant on education services provided by the humanitarian agencies.

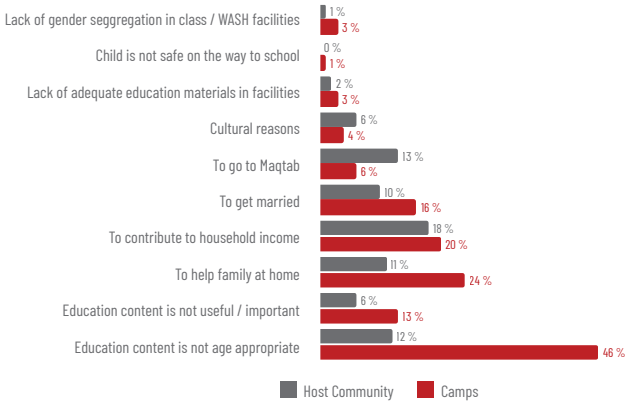
Figure 3. Type of education facilities attended by children in camps before learning centres closed due to the COVID-19 outbreak (Source: Education Sector/REACH 03/2021)



Even before the suspension of Temporary Learning Centres (TLCs) and other learning facilities as part of COVID-19 containment and risk mitigation measures, refugees had been prohibited from receiving accredited education in Bangladesh. The Government of Bangladesh had planned to begin the piloting of the Myanmar national curriculum from April 2020 in the camps, but because of the pandemic this is still not operational (UNICEF 10/02/2020).

Parents reported that education provided in the TLCs is of poor quality because children are taught to play rather than provided with a structured curriculum where students move up levels as they attain new knowledge (ACAPS and IOM 27/04/2021). Parents also reported a lack of trust in the education services due to the languages used to teach (Bangla, Chittagonian, Burmese), which hindered their ability to understand teaching materials and make educational decisions for their children. As a result, there is a preference among Rohingya for private informal education in the camps (ACAPS and IOM 27/04/2021). Informal schools in the camps that are run by respected Rohingya teachers generally lack the resources and space to meet educational demands (TNH 12/11/2019). They also usually charge for admission to cover costs and pay the teachers, which many households cannot afford (TNH 12/11/2019).

Figure 4. Reasons reported by caregivers with children who were not attending education centers in the 30 days before schools /LC closure (Source: Education Sector/REACH 03/2021)



as significant barriers preventing children and youth from accessing education, particularly adolescent girls (REACH 03/2019, J-MSNA 2019, CPSS Partners 24/10/2019). Caregivers reported cultural reasons for non-attendance for 65% of out-of-school girls, and non-attendance due to marriage for 24% (REACH 03/2019). Girls are often withdrawn from school when they reach puberty to take on domestic responsibilities or because they are forced into early marriage (NPM Round 15 09/2019, J-MSNA 2019). Some Rohingya families also practice purdah, reducing girls' mobility. Fear of both physical and verbal harassment also prevented girls from accessing education and participating in community activities. Insufficient gender segregated latrines and classrooms were additional barriers for girls in the camps (JRP 2020, CPSS Partners 24/10/2019). Girls find themselves in a trade-off situation where they have to choose between accessing services and assistance and upholding their dignity (ACAPS and IOM 27/04/2021).

Access to education differed significantly based on age. Approximately 69% of refugee households reported at least one child between 5-17 not benefitting from learning opportunities (JRP 2020). Over 85% of households had

children aged 6-11 attending TLCs (J-MSNA 2019). However, 83% of adolescents and youth aged 15-24 did not have access to appropriate educational or skills development activities due to a lack of capacity in the learning centres (JRP 2020, REACH 03/2019).

Children with disabilities encountered additional barriers to education, such as difficult terrain, congested spaces, and a lack of ramps and other physical adaptations in TLCs that hindered mobility (JRP 2020). Disabilities related to communication, speech, hearing or visual impairments were also barriers faced by children in accessing education. Lack of inclusive teaching and learning materials and the fact that very few staff reported receiving training to support children with disabilities resulted in children with disabilities being less likely to have attended learning facilities than their peers (JRP 2020). Prior to COVID-19, only 19% of children aged 3 to 5 and 53% of children aged 6 to 14 with a disability attended learning centres, compared to 65% and 73% of their peers without a disability (REACH 31/12/2019).

Prior to the refugee influx in 2017, both Teknaf and Ukhiya lagged behind the national average for development indicators. Teknaf had the lowest literacy rate in Cox's Bazar district at 26%, and Ukhiya had a literacy rate of 36.30% (District Statistics 2011, UNDP 11/2018). By 2019, one third of host community households reported at least one primary or secondary school-aged child (5-17) not attending any formal or informal learning facilities, and 32% of the 1,321 host community households surveyed for the 2019 J-MSNA reported needing children to contribute to the household income as a barrier to accessing education (J-MSNA 2019).

Even prior to the pandemic, school expenses were reported as a barrier to education for the host community. Many households could not afford uniforms, examination fees, transportation, and stationary (J-MSNA 2019). Parents were also required to pay tuition fees for secondary school, which explains why far fewer people aged 18-24 had completed secondary education in 2019 (16% males and 13% females)(J-MSNA 2019). Quality of education also reportedly declined because many local teachers sought higher-paid NGO jobs in the Rohingya refugee camps (JRP 2020). Children reported feeling unsafe because of the sudden influx of people in their neighbourhoods, which in turn limited their mobility and access to services including education (J-MSNA 2019). Girls were more likely than boys to be pulled out of education because of a combination of increased mobility restrictions, safety concerns after the 2017 influx, and pre-existing cultural norms around child marriage or household labour (UNDP 01/11/2018, ACF, Save the Children, Oxfam 01/08/2018, J-MSNA 2019).

During COVID-19

Impact of COVID-19 containment measures on the provision of education services in the camps

Since March 2020, schools and learning centers in camps have been closed in line with national COVID-19 containment measures. Movement restrictions and risk mitigation measures have also disrupted education in camps. The Government of Bangladesh has not included education as one of the essential services during the COVID 19 containment, and Education Sector partners do not have direct access to children in the camps (Education Sector 12/10/2020).

Prolonged school and learning center closure in Bangladesh has contributed to children - both host community and Rohingya - dropping out of school. Higher dropout rates imply increased rates of child labor and child marriage as result of financial constrain due to the pandemic (REACH 29/03/2021, Citizen's Platform for SDGs 01/01/2021, BBC Media Action 20/12/2020). Educational institutions act as a protective mechanism, and the fact that children are forced to stay home increases protection risks such as violence in the home.

Children in camps were struggling to access education even before the pandemic, but as students were forced to move to distance learning, the refugee community were disadvantaged in terms of education service provision

Findings from the REACH assessment conducted between October 2020 and February 2021, show that the closure of learning centers and the move towards remote learning modalities widened inequities and strengthened existing challenges for Rohingya children in accessing education. The majority of refugee households surveyed between July and August 2020, reported having faced challenges in supporting their children studying at home (J-MSNA 2020). Challenges have continued to be reported in early 2021, with 61% of caregivers in camps reported that their children had no access to any learning modalities and technologies. 65% of caregivers reported that their children had no access to electricity for learning purposes and 90% reported children are unable to access the internet. However, internet-based methodologies were not fully developed or utilised in the camps, therefore access to the internet does not necessarily mean accessibility to education (REACH 29/03/2021). It is important to note that, as of the end of 2020, 78% of school-aged children from the refugee community were not studying, 28% of which are not studying because of non-COVID-19 related reasons (REVA 4 07/02/2021), which indicates that students in the camp have barriers to education beyond those created by COVID-19 containment measures.

Lack of appropriate space to work and caregiver support were identified as some of the mains barriers to education by teachers

More than half of teachers in camps have identified access to appropriate space to work at home as the main barrier for remote learning, and lack of caregiver support was also scored highly. The large proportion of teachers reporting barriers related to work space at home can be linked to the increased number of home visits. 71% of surveyed Rohingya teachers have daily contact with students. It is important to note that caregivers reported much lower frequencies of contact, only 17% of caregivers agree that teachers have daily contact with the students (REACH Initiative 29/03/2021).

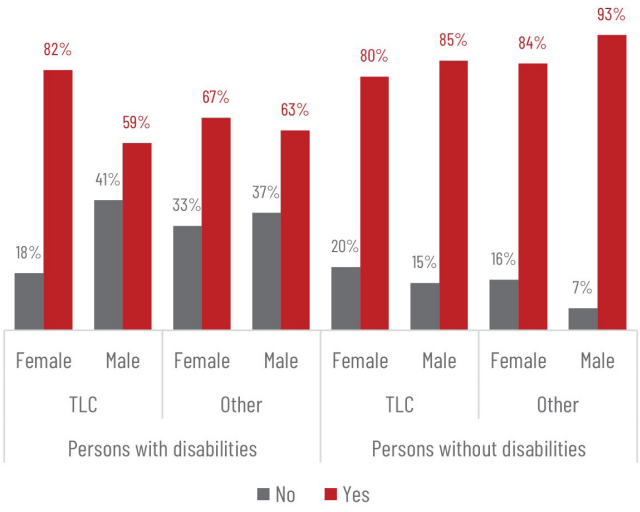
Gender gaps highlight the existing inequalities that have been exacerbated by COVID-19

In comparison to 2019, education enrolment among the Rohingya community, in particular among adolescents, and especially adolescent girls, remained low. According to REACH, a gender imbalance can be observed in camps for students aged 11 to 18 where female students seem less likely to be enrolled than male students. This trend increases by age, as girls are more likely to drop out of schools when they reach the age of 10 (REACH 29/03/2021). This is consistent with findings in the REVA 4, where 40% of school-aged Rohingya girls are currently not studying due to non-COVID-19 related reasons, 2.5 times higher than boys. These gender gaps also highlight the existing inequalities that are exacerbated by COVID-19, and the longer temporary learning centres (LCs) continue to be closed, the more likely this gap is to increase. The longer children, especially girls, are out of school, the less likely they are to return (J-MSNA 2020, REACH 29/03/2021).

Children with disabilities were generally more likely than children without disabilities to be reported as not attending a TLC or other educational facility

Children with disabilities (CwD) were already less likely to go to school in a pre-crisis context. According to an assessment conducted between November 2020 and January 2021 in Rohingya camps, 18% of girls with disabilities and 41% of boys with disabilities reported not having attended a LC and 33% of girls with disabilities and 36% of boys with disabilities not having attended other educational institutions at least 4 days a week or having attended home-based learning activities prior to the closure of education centres due to COVID-19, these percentages are lower in children without disabilities in the same period (REACH 05/2021). Data shows that among children without disabilities boys are often more likely to be enrolled in educational facilities, it is girls that are more likely to have access among children with disabilities.

Figure 5. Percentage of individuals with and without disabilities aged 5-14 attended TLCs or LCs for at least 4 days a week prior to the COVID-19 lockdown (Source: REACH 05/2021)



School closures impacted access to education and increased protection risks for children in the host community, with financial constraints reported as the main barrier to accessing remote learning consistent with 2019

For the host community, 31% of households reported at least one school-aged child (5-17 years old) not having attended any formal learning for at least four days a week prior to school closures due to the COVID-19 outbreak (J-MSNA 2020). Economic constraints remain the main barrier to accessing education (REACH 29/03/2021). This is consistent with findings from mid-2020 from J-MSNA where one of the main barriers reported for accessing distance learning for the host community was the inability of parents in poor families to support in education due to lack of money (J-MSNA 2020). In an assessment conducted in early 2021, half of host community households responded that the most commonly reported challenge in accessing distance learning modalities is financial (REACH 29/03/2021).

Adolescent girls in the host community are reportedly anxious, depressed and frustrated as a result of the school closure, difficulty coping with online classes, increasing involvement in household tasks. They are also worried of being married off to cope with family financial problems as suggested by media reports. During the pandemic the child marriage contitues to increase as marriage ceremony are cheaper (Dhaka Tribune 12/12/2020, BBC 31/12/2020, BBC 14/01/2021).

Across the host community, school closures also

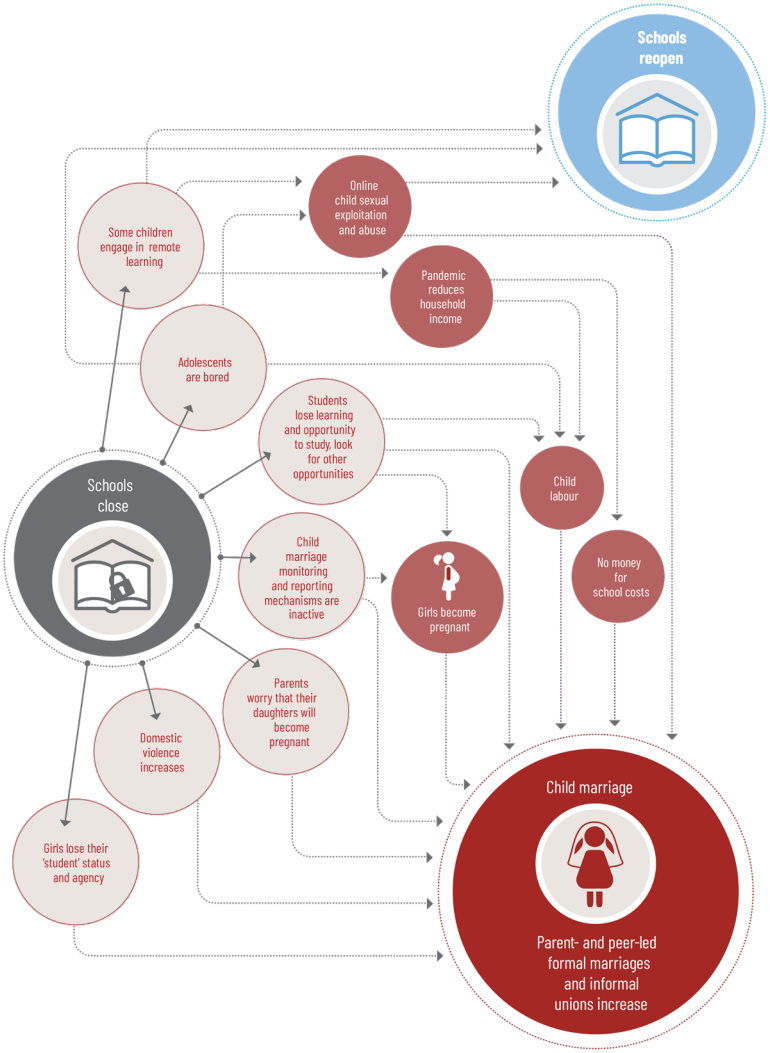
contributed to an exacerbation of protection risks for children, reportedly posing concerns not only to education but also to children's well-being. Child protection issues were reported to have increased since the lockdown, in particular child labour (J-MSNA 2020). Multiple reports have indicated a perception increase in the rate of children dropping out of school and from other learning opportunities as a result of the prolonged closure of schools and learning centres.

The prolonged closure of schools continues to increase protection issues and risk setting back improvements made in the education sector in 2019. It is also expected that dropping out of education will affect future prospects of children

An increase in daily infection rate and a surge in deaths has pushed back the re-opening date of schools until June (UNB 30/03/2021, Dhaka Tribune 26/05/2021). As school closures keep getting extended, for over a year now, the risk of more children dropping out, and the increase in associated risks continue to be a concern. It is also unclear how much learning those who continued distance learning actually had (REACH 29/03/2021). Evidence provided gives an overall indication of the impact of COVID-19 on the education sector, but the magnitude of the impact of COVID-19 on education can only be evaluated once schools reopen.

In the longer term, higher rates of dropout from both communities have an implication on increased risk of child, early, and forced marriage. Children who dropped out of school during the pandemic and those who were not able to access remote learning have now missed over a year worth of schooling, it is unclear how and if they will be able to be reintegrated into the education system. Missing out on learning opportunities also have long-term implications on child and youth growth and skills development and in turn will impact future prospects and earnings (Citizen's Platform for SDGs 01/01/2021).

Figure 6. Risk pathways of school closure (Source: UNICEF 10/03/2021)



According to the REVA 4, households headed with completed primary education show significantly lower levels of vulnerability and are more likely to have regular income sources and participation in self-reliance activities (REVA 4 15/04/2021). If this generation of primary school students drop out as a result of school closures, it will likely risk the improvements made in the education sector until 2019 as well as risk the long term economic damage to future generations (REACH Initiative 29/03/2021, REVA 3 04/2020, REVA 4 15/04/2021). As the containment measures from the latest lockdown continue to impact the livelihoods of households, particularly the host community, and the cost of education continues to act as a major barrier to accessing education, less host community households will be able to meet school costs.

LIVELIHOODS AND FOOD SECURITY

Pre-COVID-19

In 2019, an estimated nine out of 10 Rohingya households resorted to livelihood based coping mechanisms to fulfil their food or non-food needs (REVA 3 20/05/2020). This included selling food/non-food assistance, borrowing money, and/or asking for support from relatives and friends. Large households (>5 members) with many children and households with adolescent boys and girls, without a working-age male, or with chronically ill ordisabled member were among the most vulnerable (REVA 3 20/05/2020). Many children said they eat the same meal of rice and lentils every day and do not get nutritious food such as vegetables, fish and meat (SCI, PI, WVB 24/02/2018). Rice dominates the diets of refugee households (REVA 3 20/05/2020).

Prior to the pandemic, 52% of refugee households had at least one family member earning an income. Most income was generated through NGO/UN volunteer programs or as unskilled casual labour. Approximately 5% of surveyed households had children under the age of 18 working (J-MSNA 2019).

In the host community, overall vulnerability to food insecurity remained comparable through 2017, 2018, and 2019, at 41% (REVA 3 20/04/2020). Households with five or more children were more vulnerable, likely due to the constant care and attention required which impeded women from participating in income-generating activities because women continue to bear the burden of unpaid care work (REVA 3 20/04/2020). As a result, households with a high dependency ratio (>2) were more likely to resort to negative coping mechanisms, such as buying less preferred food, borrowing food, reducing portion sizes, and/or reducing the number of meals per day (REVA 3 20/04/2020).

During COVID-19

COVID-19 and the impact of sustained shocks hampered livelihood and self-reliance activities in Cox's Bazar district. Throughout 2020, households in Cox's Bazar are forced to adopt crisis and emergency coping mechanisms

The reduced humanitarian footprint in the camps as a part of containment and cautionary measures impacted income opportunities, households' purchasing power, and threatened food security (WFP 26/01/2021). As a result, some households have resorted to negative coping strategies, including child labour and early marriage - see Protection section . According to the REVA 4, households with infants (below 5 years of age) and adolescents (5-15 years of age) were associated with a higher use of negative coping strategies (REVA 4 15/04/2021). Children under five with pregnant and lactating women are among the most vulnerable groups affected by reduced food stocks in homes as families adopt mitigation measures to cope with reduced income in households (World Vision 09/07/2020).

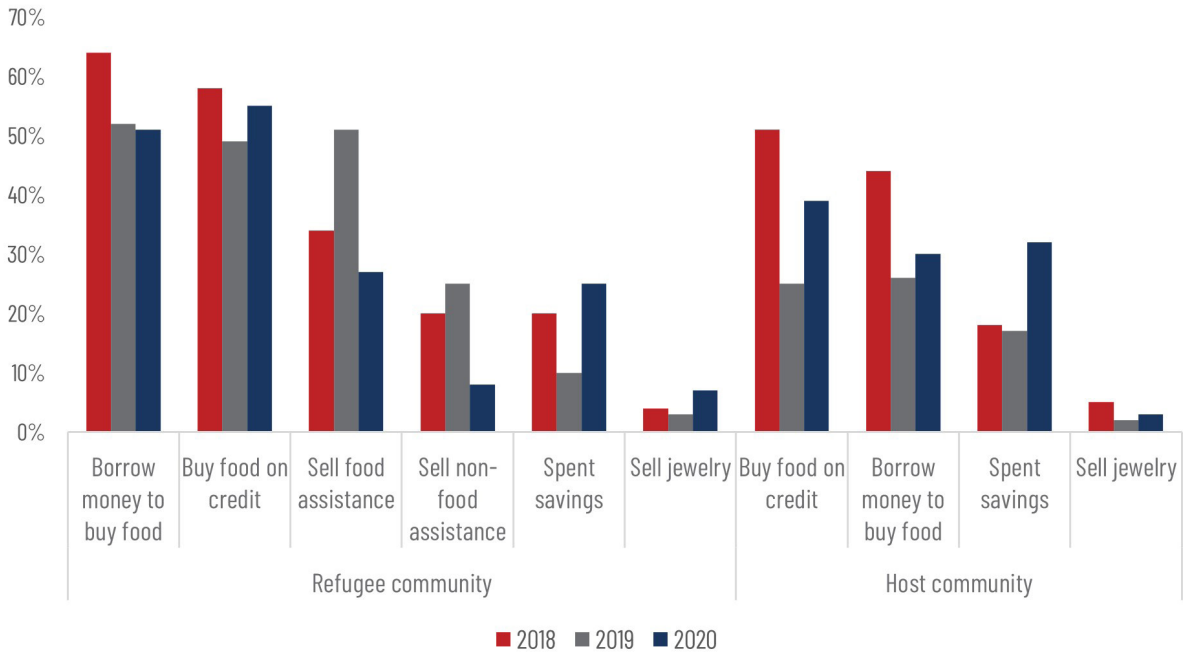
Nine out of 10 Rohingya households surveyed for the REVA 4 reported adopting at least one livelihood-based coping strategy. The most used strategies by the Rohingya refugees were buying food on credit (55%) and spending savings (25%), increasing by 15% and 6% respectively compared to the previous year. These coping mechanisms are considered stress strategies that are irreversible and reduce the ability of households to deal with future shocks (REVA 4 15/04/2021).

80% of Rohingya households reported adopting consumption based coping strategies (REVA 4 15/04/2021). This is somewhat consistent with findings from the refugee J-MSNA, which found that 71% of households reported food-based coping strategies in the seven days prior to data collection. The wide use of these coping strategies indicates that there were food shortages and consumption gaps as a result of reduced diversity of food assistance, which was caused by the change in modality of assistance[3] as a result of COVID-19 containment and risk mitigation measures (J-MSNA 2020, ISCG, Care, Oxfam, and ACAPS 14/10/2020).

3 April to November 2020, WFP shifted from a value voucher (e-voucher) to a commodity voucher system to minimise virus transmission risks (WFP 01/2021, WFP 06/11/2020).

Given that 55% of surveyed Rohingya households contained children under five (REVA 4 15/04/2021), the adoption of consumption based coping strategies is expected to impact children. The deterioration in the food security situation due to COVID-19 containment and risk mitigation measures and a further reduction in health services are likely to worsen the nutrition status of children under the age of five (DRC 22/10/2020, UNCTB 16/09/2020, J-MSNA 2020).

Figure 7. Periodical (2018-2020) trend in adoption of livelihood based coping strategies (Source: REVA 4 15/04/2021)



Among the host community six out of 10 households reported adopting at least one livelihood-based coping strategy. Host community households were also increasingly dependent on spending savings and buying food on credit compared to 2019 (REVA 4 15/04/2021). Paying back these debts will remain a burden on these households in the long term (Dhaka Tribune 15/04/2021, REVA 4 15/04/2021).

40% of host community households adopted food/ consumption based coping strategies in 2020 (REVA 4 15/04/2021). Given that 44% of households surveyed have children under five, the lack of food and the widespread use of consumption-based coping strategies is expected to impact children. Data from early on in the lockdown period, in May 2020, shows that 39% of households reported that children had a maximum of two meals a day with 61% reporting that children had three meals daily (World Vision 09/07/2020).

As of April 2021, there has been a new nationwide lockdown which will impact both Rohingya and host community households who are yet to recover from the impact of the pandemic in 2020. One year's economic loss resulting in increased economic vulnerability will negatively impact the food security status of households and may result in an increase in the use of emergency and crisis coping strategies (REVA 4 15/04/2021, ACAPS 30/05/2021). Another new directive followed up from the government on limiting humanitarian footprint and activities on 16 May 2021.

NUTRITION

Pre-COVID-19

Although global acute malnutrition (GAM) rates in the camps reduced substantially from 19.3% after the influx in 2017 to 10.9% in October 2019, anaemia prevalence among children aged 6 to 23 months remained a significant public health concern, at 59.6% (JRP 2020). Stunting also remained high at 32.6%, most likely due to barriers to accessing fresh and diverse food, which results in poor dietary diversity (JRP 2019).

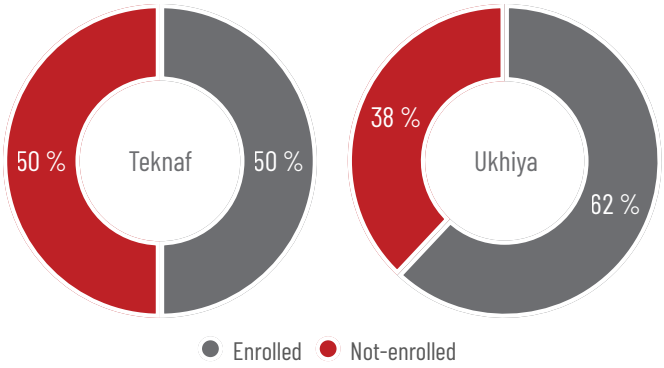
Pre-existing food insecurity, poor food consumption, and water quality and poor sanitation and hygiene practices contributed to high malnutrition and stunting rates, with 11.6% of host community children underweight and 30.7% severely stunted, indicating chronic malnutrition (World Bank 10/11/2016). Access to a diverse diet was aggravated by increased market demand and price hikes post-influx. The REVA 3 vulnerability assessment showed that before the pandemic, approximately 32% of host community households were estimated to consume two food groups or fewer per day and access to nutritious foods remained low (REVA 3 20/04/2020).

During COVID-19

The impact of COVID-19 containment measures on access to nutrition services

While nutrition services were considered essential under the directives from Government of Bangladesh in March 2020 and humanitarian activities were allowed to continue, outreach and consultation services were scaled down. The number of nutrition staff present per facility was reduced from 10 to three, which was later increased to five in October 2020 (UNICEF 01/02/2021, ACAPS 07/05/2020). As a result, community mobilization, house to house screening for malnutrition, and camp level nutrition activities were reduced during the lockdown period. Access to or the utilisation of nutrition-feeding programmes were also impacted. According to the 2020 J-MSNA[4], 30% of households with pregnant and lactating women (PLW) reported that PLW in the household were not enrolled in a nutrition-feeding programme and 40% of children aged 6 to 59 months were also reported not being enrolled. Ukhiya reported more children being enrolled in a nutrition-feeding program than Teknaf (J-MSNA 2020).

Figure 8. Percentage of children aged 6-59 months enrolled in nutritional feeding program (Source: J-MSNA 2020)



The decrease in nutrition services was also reflected in levels of satisfaction with related assistance. The proportion of households reporting nutrition assistance had "gone well" decreased by 12%, while the proportion of households that reported nutrition assistance "not to have gone well" increased by 8% (J-MSNA 2020).

Other factors that impacted the nutrition of children in the camps include changes in food distribution modalities (which lasted from the beginning of the first lockdown in March 2020 until late 2020), market shortages, decrease in income, and school closures, all of which have reduced access to and diversity of food (ACAPS 07/05/2020, J-MSNA 2020). Throughout 2020, 55% of mothers in camps reported having to feed their children less diverse foods, while 46% reported food shortages and feeding less food to their children (UNICEF 01/02/2021). The REVA 4[5] found that unregistered[6] Rohingya households consumed less vitamin A, protein and Haem[7] iron rich foods, indicating that children in these households lacked nutrients in their diets and were therefore at higher risk of malnutrition (REVA 4 15/04/2021).

4 Data collected from July to August 2020 (shortly after the end of the first lockdown)

5 Conducted between November and December 2020

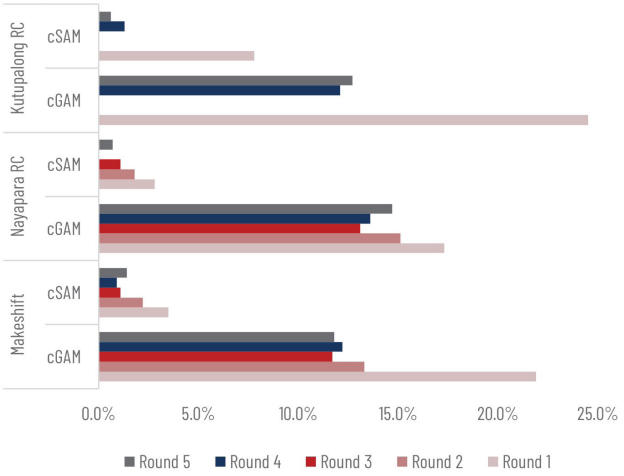
6 Rohingya can be categorised into three groups by registration status: registered as refugees by UNHCR, registered as forcibly displaced Myanmar nationals, and few remain completely unregistered (ACAPS 20/12/2019)

7 Dietary iron exists in two forms: haem iron (ie, iron in haemoglobin), found in meat, and non-haem iron (mainly in the form of iron salts), found in grains, fruit and vegetables.

GAM and SAM prevalence in Rohingya camps

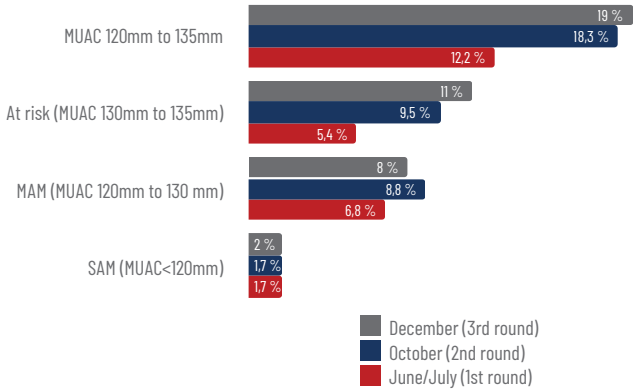
According to a nutrition assessment conducted in Makeshift, Nayapara, and Kutupalong registered camps between November and December 2020, Global Acute Malnutrition (GAM) rates have slightly increased in Nayapara and Kutupalong camps according to combined criteria (WHZ[8] and MUAC[9]) in comparison to the previous round conducted in late 2019 (pre-COVID-19), while they decreased slightly in the Makeshift camps. Severe Acute Malnutrition (SAM) rates increased in the Makeshift and Nayapara camps but decreased in the Kutupalong camps. The current GAM rates for all three camps are of serious severity according to the WHO/UNICEF classification (ACF 26/01/2021).

Figure 9. Trends of acute malnutrition by combined criteria (Source: ACF 26/01/2021)



While GAM and SAM differences between round 4 and round 5 in the nutrition survey appear to have been small, the impact of COVID-19 on malnutrition is likely to manifest in the long-term. This is evident by the gradual increase in GAM malnutrition rates of children under 5 based on mass screening throughout 2020 - as shown below. However, SAM rates remained unchanged throughout 2020 by MUAC indicator (UNICEF 01/02/2021).

Figure 10. Malnutrition rates of children under 5 based on mass screening (Source: UNICEF 01/02/2021)



In round 5, chronic malnutrition rates decreased in Nayapara Camp by 9.9% in comparison to the previous round. However, it continues to be of high severity. Chronic malnutrition rates in both the Makeshift and Kutupalong camps remain very high (>30%) (ACF 26/01/2021).

GAM and SAM prevalence in the host community

According to a nutrition survey conducted in the host community in Ukhiya and Teknaf between January and February 2021, the GAM prevalence by WHZ in Ukhiya is 1% higher than Teknaf, whereas GAM prevalence by combined criteria (GAM and MUAC)[10] is at similar levels in the two upazilas (considered of medium severity by WHO/UNICEF classification). The prevalence of SAM measured by both the WHZ and combined criteria in Ukhiya is 0.9% and in Teknaf it is 0.5% (WHZ) and 0.7% (WHZ and MUAC) (ACF 25/03/2021).

Children in the host community, especially those from rural areas, and poor households, are expected to be impacted by the ongoing lockdown due to the loss of income and the prolonged closure of schools. Children from poorer backgrounds are vulnerable to poor nutrition as their families had to cut down their nutritional intake and reduce their daily expenditure to cope with the financial constraints resulting from the pandemic (Gage 30/04/2021). Children in rural areas and from the poorest households, along with the children with disabilities, are at risk of undernutrition due to the disruption of school feeding programs as a result of the school closures (UNCTB 16/09/2020).

8 Weight-for-Height Z Score

9 Mid-Upper Arm Circumference

10 There is poor concordance between weight-for-height z-score (WHZ) and mid-upper arm circumference (MUAC) in the identification of malnourished children. The difference shows that using MUAC only is not sufficient, and can lead to a number of children left undiagnosed

HEALTH

Pre-COVID-19

Research conducted in the camps six months after the influx indicated that adolescent girls were aware of health services available to them and were accessing healthcare services within the camps. However, the available medication was perceived as inadequate, preventing them from seeking services in the future. Distance, lack of transport, and economic barriers were also reported as barriers (Plan International 20/06/2018). Common health issues for married adolescent girls include anaemia and malnutrition and giving birth to underweight babies (Save the Children 03/06/2019). Sociocultural norms imposed by older family members was the largest barrier to adolescents and youth seeking information about sexual and reproductive health (SRH), particularly contraception (Plan International 20/06/2018, UNFPA 10/2018). This is supported by UNFPA's research on maternal and sexual reproductive health, which found that while available, reproductive health services are often inaccessible for Rohingya adolescents and youth in the camps (UNFPA 10/2018). To mitigate the issue, a programme where community health workers visit households each week was introduced (Health Sector/WHO).

Prior to COVID-19, the most common challenges in accessing healthcare for host community youth and adolescents were long distances to services (33%) and high costs related to obtaining services (18%) (J-MSNA 2019). The average wait times for host community members to access health services increased by 50% since the 2017 influx (UNFPA 01/11/2018). Host community members reported a direct link between the influx and the increase in health conditions such as skin disease, diphtheria, diarrhoea, and malaria due to overloaded water and sanitation systems, overcrowded living conditions, and a deteriorated environment (UNFPA 01/11/2018).

During COVID-19

Social stigma, mistrust in authorities, fear of seeking health services, and lack of information about health services during the pandemic affected access to healthcare

The capacity of health providers was overstretched due to increased demand in services for the COVID-19 response and the suspension of some activities due to precautionary/ containment measures. In early 2020, this resulted in gaps in delivery in immunizations, maternal and family health, and services for GBV survivors. After an initial dip, the situation improved in health services coverage, but social stigmas, fears of seeking health services and lack of information about health services during the pandemic significantly affected access to healthcare (JRP 2020 Mid-Term 30/11/2020). Women and girls reported feeling unsafe in mixed health facilities due to the risk of GBV and abuse, while families also expressed unwillingness to separate (JRP 2020 Mid-Term 30/11/2020).

In the first three months of the first lockdown in 2020, the total number of consultations in health facilities dropped by over 50% (WHO 21/06/2020). This reduction was attributed to fears around COVID-19, mistrust in authorities, and misinformation (ISCG, Care, Oxfam, UN Women and ACAPS 14/10/2020). While consultations have since recovered, closure of health-adjacent services and limited operating hours for some health facilities has led to overcrowding, increased waiting times, and decreased patient satisfaction. At the same time, restrictions on travel and transport have made referrals for medical reasons, including emergency obstetric care, more cumbersome, and the newly erected fences in the camps have made access to health services more difficult in places.

Routine immunization resumed in July 2020, after being temporarily suspended in mid-April 2020, but catch-up efforts are required to capture those who missed out, especially children

Routine immunization coverage, which was already low among Rohingya refugees, declined further since the outbreak of COVID-19 as lockdown restrictions temporarily suspended immunization and outreach services. The immunization fixed sites that remained open during the lockdown experienced a very low number of beneficiary visits. Routine immunization resumed in July 2020 (WHO 29/07/2020, UNHCR 09/11/2020). Continued efforts are needed through tracking missed children, supplementary immunization activities (SIAs), or campaigns to increase coverage among children that have been missed due to the effects of COVID-19 and limited baseline health-seeking behavior for routine immunization.

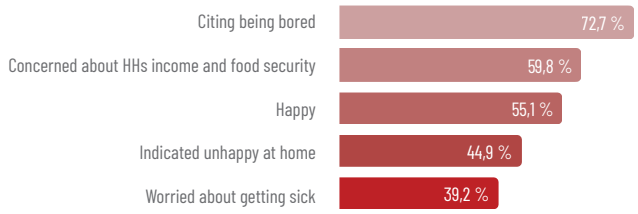
Between October 2017 and February 2020 several rounds of oral cholera vaccination campaigns were carried out. With protection waning significantly after two years, most of the population would benefit from the protection of a new round of cholera vaccination, particularly considering confirmed cholera cases in the second quarter of 2021 (Health Sector/WHO).

More than half of children felt isolated and distressed during the first lockdown. With the on-going second lockdown and school closures it is expected that children's mental health will continue to be impacted.

Stress and anxiety among caregivers is pushing them to engage in negative behaviours towards children.

COVID-19 and accompanying containment and risk mitigation measures resulted in loss of income, economic hardship, loss of education, and isolation, all of which are causing stress and anxiety among parents and caregivers (World Vision 09/07/2020, JRP COVID-19 Addendum 22/07/2020). Consequently, children have faced physical punishment and psychological aggression from their parents and caregivers (GAGE 30/04/2021, Dhaka Tribune 15/04/2021). These issues have likely continued or worsened as the drivers persisted, especially because mental health and psychosocial support services (MHPSS) were considered not essential and therefore were not permitted during the lockdown.

Figure 11. Concerns shown by children while staying at home during COVID-19 lockdown in 2020 (Source: World Vision 09/07/2020)



COVID-19 has increased fear, anxiety, and worry among children. Loss of education opportunities has also impacted the mental health of children and adolescents (ISCG, Care, Oxfam, UN Women and ACAPS 14/10/2020). The fires that have been breaking out across the camps since the beginning of 2021, and most notably the huge fire on 22 March, have likely exacerbated this anxiety, fear, and discomfort among children, further hampering their physical and mental wellbeing (IOM 30/03/2021, BRAC 01/04/2021). According to WHO, children living in situations of displacement are at increased risk of impaired development, which can have life long implications. Holistic approaches to child/family wellbeing, the re-establishment of routines as quickly as possible, and paying attention to social cohesion and encouraging positive relationships between displaced and host communities are key principles to observe for early childhood development.

COVID-19 and the accompanying containment and risk mitigation measures also affected the mental health of children in the host community. An assessment carried out among 1,600 children in 24 districts in May 2020 found that more 87% of children reported feeling isolated and 92% feeling distressed during the first lockdown (World Vision 09/07/2020). Early marriage also increased as a result of the pandemic, causing young girls anxiety and depression due to the risk of being married off (BBC 20/12/2020, BBC 31/12/2020, ISCG 06/05/2021).

WASH

Pre-COVID-19

The lack of gender segregated latrines and bathing facilities with appropriate lighting and physical adaptations in the camps were barriers to access for children, particularly girls and children with disabilities (J-MSNA 2019, ACAPS 11/03/2019, ACAPS 08/02/2021). Some households built makeshift facilities close to or inside their shelters and others engaged in open defecation in areas close to the shelters. This resulted in serious health and hygiene concerns. In 2019, it was found that open defecation was prevalent among children under 5, with 48% of girls and 44% of boys between the ages of 1-4 defecating outside (REACH 11/2019). Washing hands with water alone was reported by 13% of refugee households (REVA 3 04/2020). In 2019, water access affected six out of 10 refugee households (REVA 3 04/2020).

Women and girls reported being under informed about menstrual hygiene management (MHM) and said they received insufficient supplies (REACH 30/09/2019). This may be because MHM awareness was conducted at distribution points which women and girls do not always have access to due to sociocultural restrictions on women's movement as well as concerns of harassment (REACH 30/09/2019).

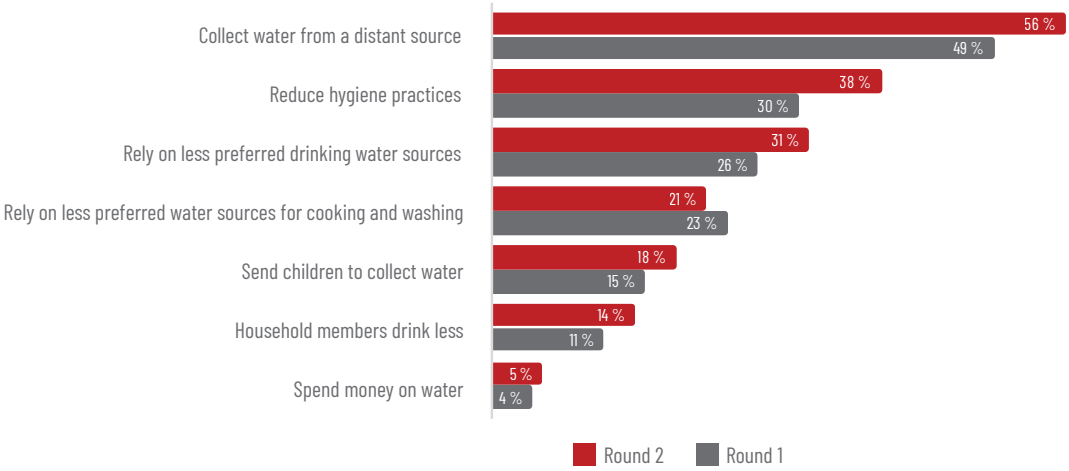
Prior to the pandemic, water access affected five out of 10 Bangladeshi households, who most frequently cited the distance to water points as their biggest issue (REVA 3 04/2020). Approximately 18% of households said they used surface water during the dry season in 2019 to meet household demands (J-MSNA 2019). 24% of host community households reported washing hands with water alone (REVA 3 04/2020).

During COVID-19

Increase in negative coping mechanisms for insufficient water in 2020, including collecting water from far away sources and sending children to collect water

An IOM assessment[11] conducted in the Rohingya refugee camps in July 2020 (Round 1), shortly after the lockdown, and again in September 2020 (Round 2), showed an increase in the number of respondents adopting negative coping strategies for insufficient water. The number of respondents reporting sending children to collect water increased by 6% from mid to end of 2020 (IOM 07/2020, IOM 09/2020).

Figure 12. Coping strategies for insufficient water in camps (Source: IOM 07/2020, IOM 09/2020)



The increase in negative coping mechanisms for insufficient water is likely to impact children. According to another survey with data collected between June and July 2020, 38% of Rohingya women and 49% of Rohingya men reported that access to latrines and bathing facilities had worsened, with only 5% of both reporting improved access. The decrease in access is partly due to WASH services decreasing in the camps which has limited the maintenance of WASH facilities such as repairing broken hand-pumps or dislodging and cleaning toilets (ISCG, Care, Oxfam, UN Women and ACAPS 14/10/2020).

Despite improvement in WASH facilities and services, WASH issues such as distance to facilities and wait times continue to be reported by Rohingya households. These problems are especially likely to affect children with disabilities

Despite overall improvement in accessing water from 2019 to 2020, according to the REVA 4 half of Rohingya households in Cox's Bazar district reported problems accessing water. The primary issue reported was distance to water points, followed by lack of sufficient water points and waiting times. The share of Rohingya households reporting sanitation problems decreased from 70% to 59%, with only 1% reported to have been using *kutcha-type* latrines and open fields for defecation. The most reported sanitation issues by the Rohingya were waiting times, cleanliness, distance from facilities, and overcrowding (REVA 4 15/04/2021). These problems are particularly affecting children with disabilities who cannot easily reach facilities or wait in lines for functioning toilets and washing facilities. Distance to facilities may also expose children to SGBV, trafficking, and kidnapping (HRW 28/04/2020).

It is important to note that WASH facilities and services have improved in the camps in comparison to 2019. The reduced humanitarian presence in the camps risks setting back these improvements (ISCG, Care, Oxfam, UN Women and ACAPS 14/10/2020). In addition, it was reported in late 2020 that soap distribution was not sufficient to maintain a family's hygiene properly (IOM 27/05/2021). According to the REVA 4, 4% of Rohingya households with children under five wash their hands only with water after defecation. While washing hands with water alone removes pathogens, it is not as effective as using soap (REVA 3 04/2020). Populations living in such conditions are more susceptible to disease spread, especially waterborne diseases such as diarrhoea.

Overcrowding and inadequate lighting heightens protection risks for girls. The combination of social and cultural taboos, increased presence of men in

11 Findings are indicative only and are not representative at the camp or overall response level. This is because the phone numbers were not distributed evenly to achieve a representative sample. The majority (90%) of the respondents are male.

shelters and delays in distributions are impacting girls' ability in accessing hygiene products and managing their periods in the camps

Girls face issues of overcrowding and lack of privacy when using latrines during the day, while at night they risk being exposed to harassment and violence due to inadequate lighting. The limited use of personal handheld lights and lamp posts increases the risk of rape, assault, or physical injury while navigating difficult terrain in the dark (ISCG, Care, Oxfam, UN Women and ACAPS 14/10/2020, ACAPS and IOM 27/04/2021).

Widespread social and cultural taboos and stigma impact how women and girls access necessary Menstrual Hygiene Management (MHM) products and manage their periods in the camps. During the pandemic, the increased presence of men in the shelters because of movement restrictions impacted the ability of women and girls to safely and privately manage their periods (ACAPS and IOM 27/04/2021). MHM has also become more difficult due to delays in distribution of materials; community feedback shows that MHM kits are provided once every six months (ISCG, Care, Oxfam, UN Women and ACAPS 14/10/2020, IOM 27/05/2021). Additionally, it has become much harder for girls to wash and dry their menstrual clothes due to lack of privacy and pre-existing social stigma. This has resulted in girls reusing wet menstrual cloths which puts them at risk of infections (ISCG, Care, Oxfam, UN Women and ACAPS 14/10/2020). MHM for adolescents with disabilities is even more challenging, especially girls with intellectual disabilities who have poor understanding of self-care and personal hygiene (WASH sector 04/2021, Inclusive MHM Practice 28/06/2020).

Although WASH-related services are exempted from the latest government directives on containment measures in April 2021 during the second lockdown, the reduced humanitarian footprint is expected to impact the regular maintenance of facilities and provision of services

WASH-related services including repair and maintenance were exempted from the suspension of non-critical humanitarian operations (RRRC 05/04/2021, WASH Sector 06/04/2020). The regulations are similar to the measures implemented in 2020, where WASH activities were allowed but mainly focused on COVID-19 awareness and hygiene promotion. WASH infrastructure building and improvements were put on hold. Due to the lack of regular maintenance, damaged fences, doors, and locks in the bathing areas have not been replaced. Refugees have to use damaged or unhealthy latrines or latrines that are far away from their houses, which increases insecurity for children, adolescents and women. People with disabilities face similar problems (Groupe URD 01/04/2021).

Water access problems such as distance to water points, lack of sufficient water points and water points not functioning properly are still reported by host community households, sanitation problems are also cited but to a lesser extent

Sanitation problems were reported by 27% of host community households. The most frequently cited problem was facilities not functioning. Despite the improvement in sanitation in comparison to 2019, around 30% of host community households are still using *kutcha*-type latrines or open fields for defecation, which gives rise to health risks. In addition, 10% of host community households with children under five wash their hands only with water after defecation (REVA 4 15/04/2021). Water access problems were more frequent, with 40% of host community households reporting issues despite improving since 2019. The main problems cited were distance to water points, lack of sufficient water points, and water points not functioning properly (REVA 4 15/04/2021).

ABOUT THIS REPORT

IMMAP and DFS are currently implementing the OFDA COVID-19 support project in six countries: DRC, Burkina Faso, Nigeria, Bangladesh, 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 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 2020-July 2021) 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 in which humanitarian actors operate. As the repository builds up, the analysis provided each month becomes more complete and robust.

For the May 2021 report, the project team had a close technical collaboration with the Child Protection Sub-Sector in Cox's Bazar to develop this "Thematic Analysis Report" focusing on the impact of COVID-19 on children. ACAPS supported in developing the pre-COVID sections of the report and contributing to the overall review.

Coordinating Sectors and Agencies: ACAPS, ACF, Child Protection Sub-Sector, Education Sector, Food Security and Livelihood Sector, Health Sector, IOM, NPM, Nutrition Sector, UNICEF, UNHCR, WFP.

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 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 13.

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)

For the "Thematic Analysis" the main framework was revised & restructured by the team focusing on children based on the suggestions & recommendations from the Child Protection Sub-Sector. A graphic representation of the revised SDAF is available in figure 14.

Figure 13. IMMAP/DFS Secondary Data Analysis Framework

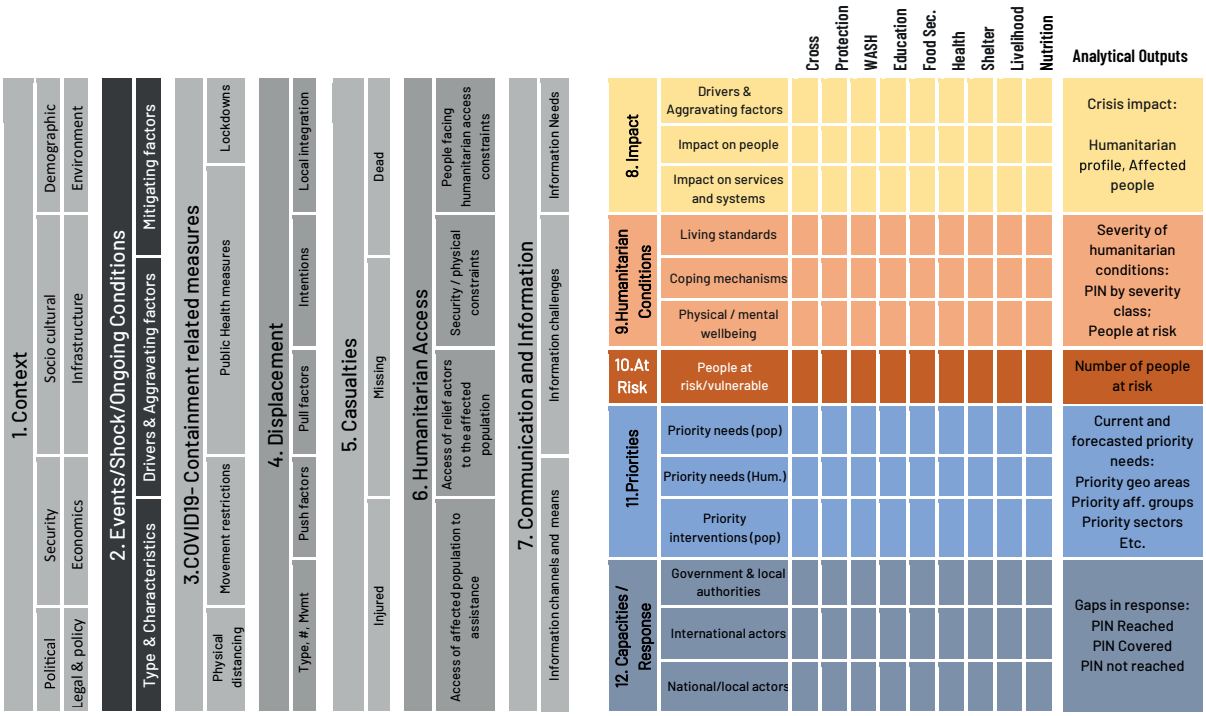
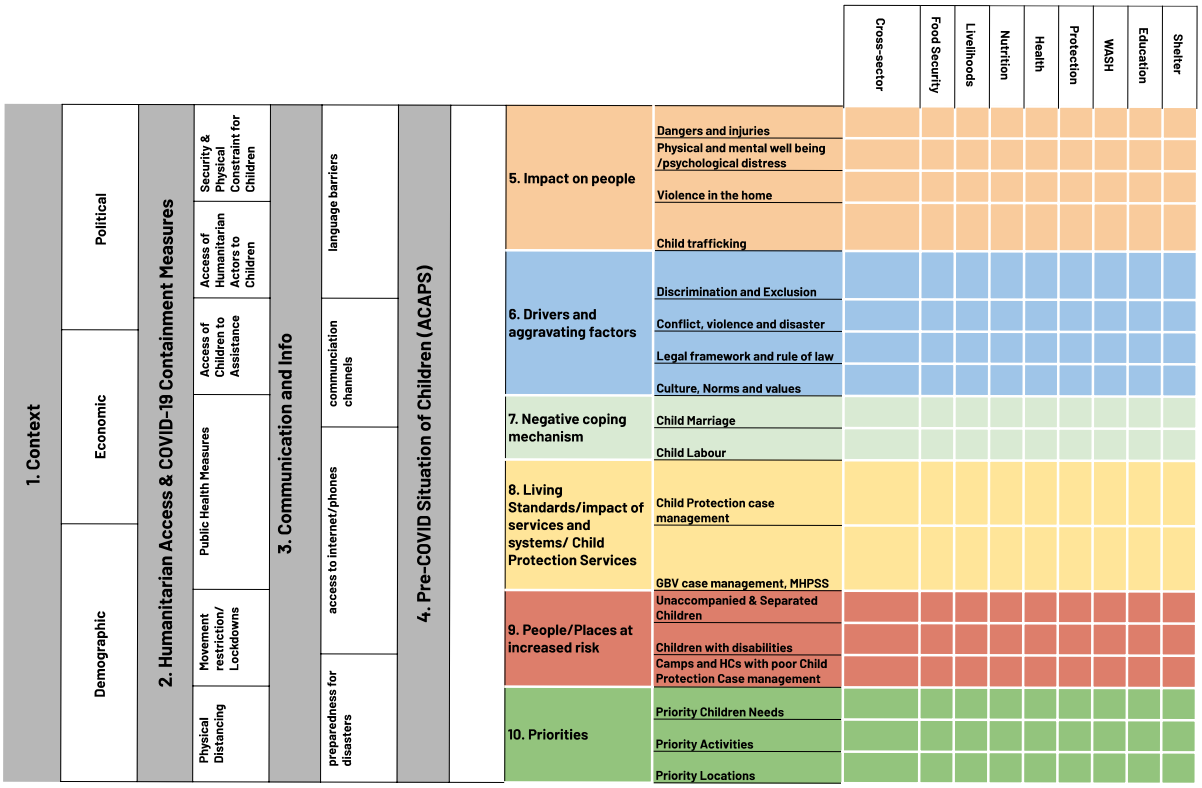


Figure 14. iMMAP/DFS Thematic Analysis Framework for Children



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 01 April 2020 to 31 May 2021 were used).

Figure 15. Documents by Location, Timeline, and Primary Categories (Analytical Framework)

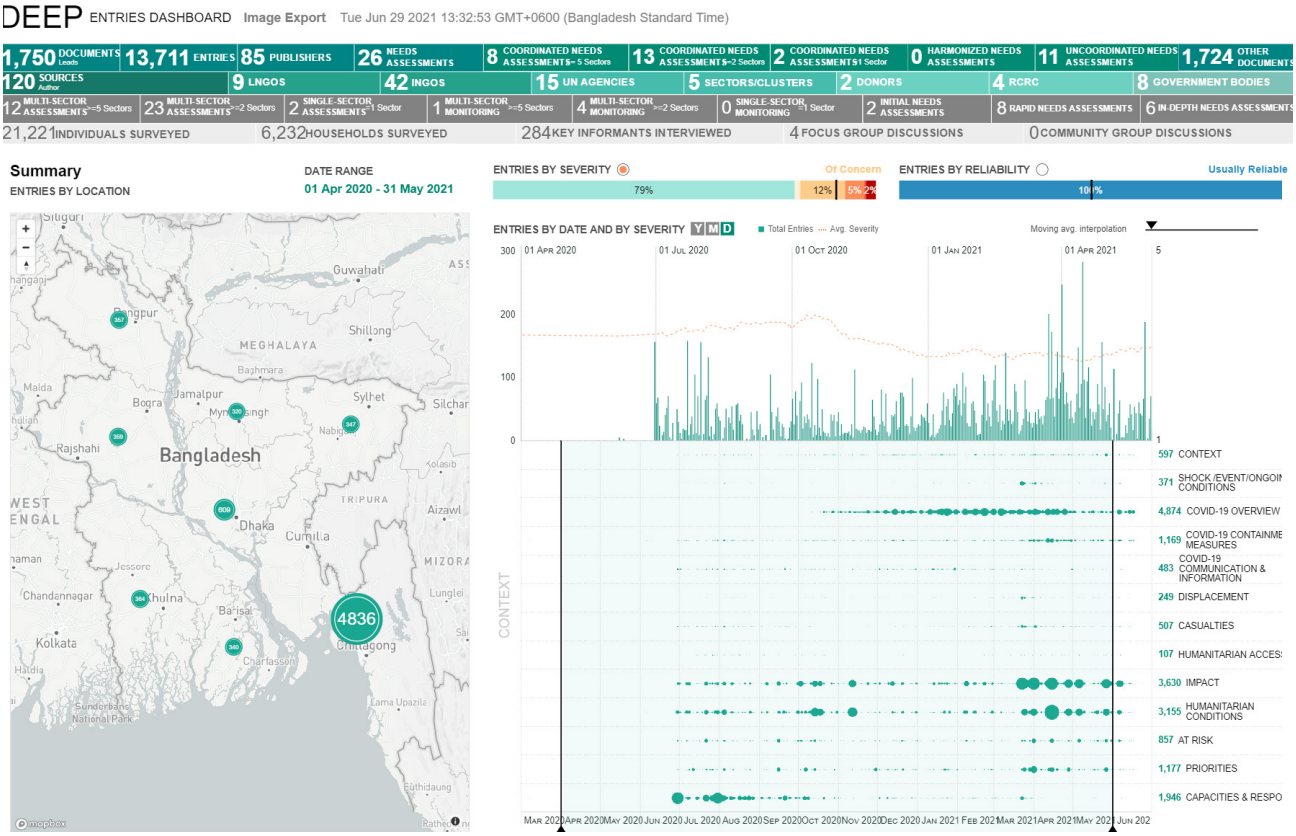


Figure 16. Documents and Entries by Sector and Affected Group

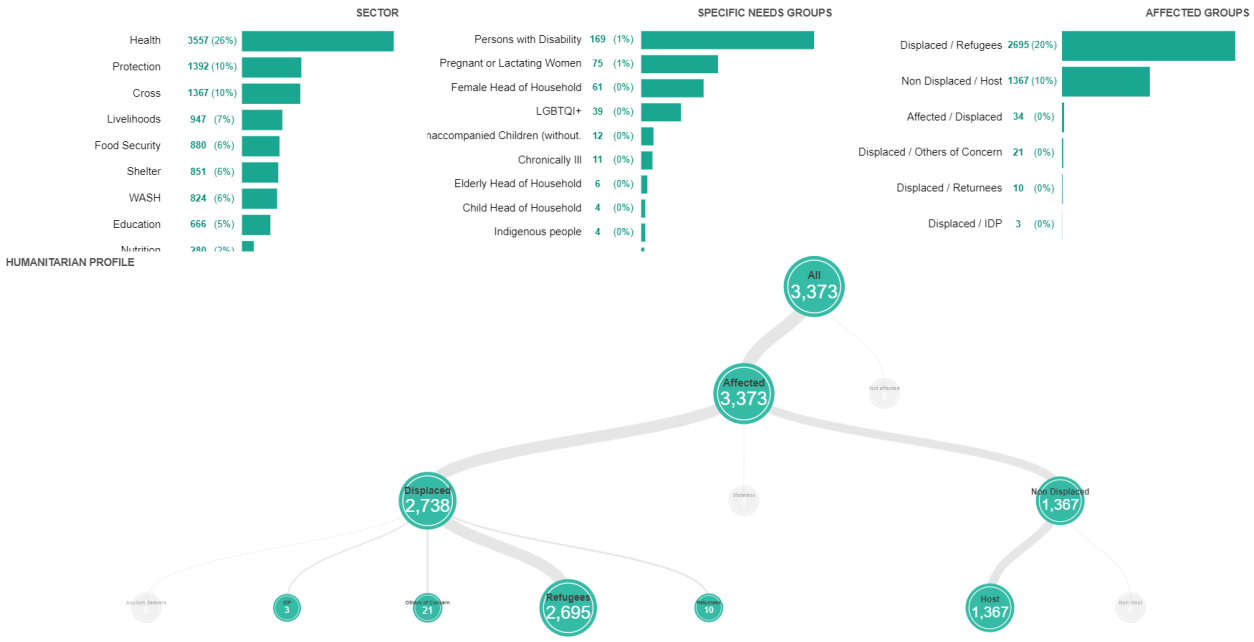
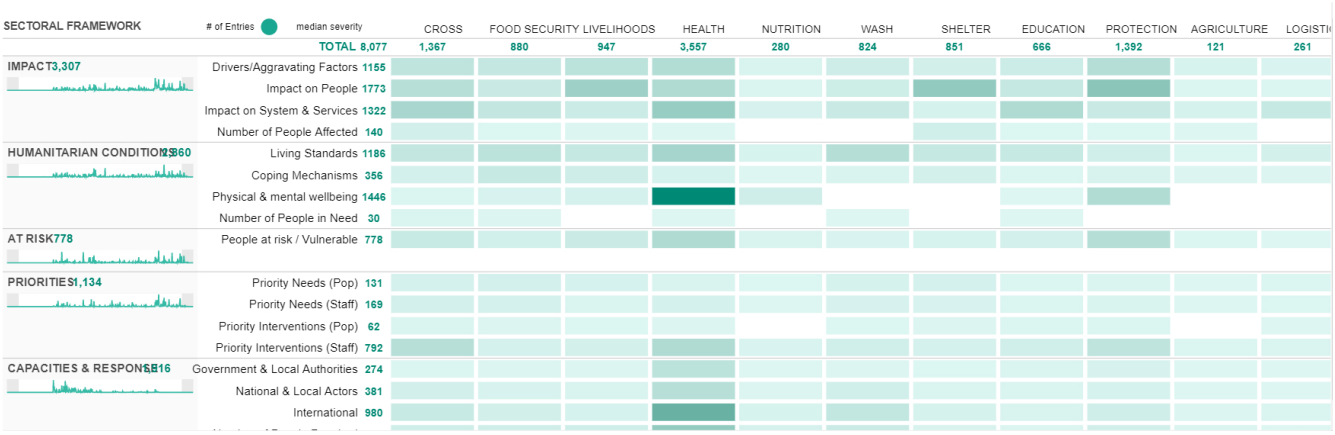


Figure 17. Entries by Sector and sub-Categories (Analytical Framework)



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 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 and adapt if necessary.
- 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.

Figure 18. 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

THANK YOU.

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