

COX'S BAZAR, BANGLADESH

# Joint Multi-Sector Needs Assessment (J-MSNA)

Rohingya Refugees

2020 MSNA





## COORDINATED BY:



## FUNDED BY:

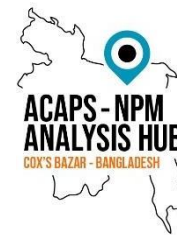


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**TRANSLATORS**  
WITHOUT BORDERS

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## EXECUTIVE SUMMARY

Over the last four decades, Rohingya refugees have been fleeing in successive waves to Bangladesh from Rakhine State, Myanmar. Periodic outbreaks of violence led to large exoduses of refugees in particular in 1978, between 1991 and 1992, and in other short waves prior to August 2017.<sup>1</sup> Since August 2017, an estimated 745,000 Rohingya refugees have fled to Cox's Bazar District, Bangladesh, where approximately 860,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas.<sup>2</sup>

With limited access to regular income and livelihoods opportunities in the camps, the Rohingya refugee population is highly reliant on humanitarian assistance.<sup>3</sup> While the crisis is now in its fourth year, a return of refugees to Myanmar in the near or medium term continues to be unlikely.<sup>4</sup> At the same time, structural factors continue to challenge the response, including a lack of formal education in camps, insufficient health, water, sanitation and hygiene (WASH) provisions, and weak shelter infrastructure.<sup>5</sup> The outbreak of the COVID-19 pandemic and associated containment measures put in place in camps on 24 March 2020 further severely restricted humanitarian access and service delivery to the highly aid-dependent refugee communities throughout much of 2020. With only a limited number of essential services having been provided,<sup>6</sup> pre-existing levels of need are likely to have been exacerbated. As such, sustained assistance and effective prioritisation for 2021 will be essential to be able to meet likely high levels of need.

As the response has moved beyond the initial emergency phase, there is a continued need for up-to-date information on the needs and vulnerabilities of the refugee population, in order to inform the design and implementation of effective inter-sectoral programming. At the same time, an understanding of the impact of the COVID-19 outbreak and associated containment measures on household-level multi-sectoral needs, capacities and access to services will be essential for a full understanding of priority needs for 2021. Against this background, a Joint Multi-Sector Needs Assessment (J-MSNA) was conducted across Rohingya refugee populations to inform evidence-based strategic planning of humanitarian response activities by the Strategic Executive Group (SEG), the Inter Sector Coordination Group (ISCG) Secretariat, sectors, and sector partners. The J-MSNA further aimed to provide an analytical basis for the development of the 2021 Joint Response Plan (JRP). It built on previous MSNAs, in particular the [2019 J-MSNA](#) with the goal to facilitate an understanding of the evolution of needs and service gaps across time, and was implemented through the ISCG's MSNA Technical Working Group (TWG) of the Information Management and Assessment Working Group (IMAWG), which is led by the ISCG and comprised of the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration Needs and Population Monitoring (IOM NPM), ACAPS, and REACH. Translators without Borders (TWB) provided additional technical support. Sectors were actively involved in research design, preparations for data collection, and the discussion of results and analyses.

<sup>1</sup> Zakaria, F. (2019), "Religion, mass violence, and illiberal regimes: Recent research on the Rohingya in Myanmar", *Journal of Current Southeast Asian Affairs*, 38(1), pp. 98 – 111.

<sup>2</sup> Inter Sector Coordination Group (ISCG), *Situation Report Rohingya Refugee Crisis, Cox's Bazar, Bangladesh, June 2020* (Cox's Bazar, 2020a). Available [here](#) (accessed 13 November 2020).

<sup>3</sup> World Food Programme (WFP), *Refugee influx emergency vulnerability assessment (REVA) – Cox's Bazar, Bangladesh (April 2020)* (Cox's Bazar, 2020a). Available [here](#) (accessed 13 November 2020).

<sup>4</sup> International Crisis Group (ICG), *A Sustainable Policy for Rohingya Refugees in Bangladesh*, Asia Report N°303, 27 December 2019 (Brussels, 2019). Available [here](#) (accessed 13 November 2020).

<sup>5</sup> WFP, 2020a; ICG, 2019.

<sup>6</sup> ISCG, *2020 COVID-19 Response Plan, Addendum to the Joint Response Plan 2020, Rohingya Humanitarian Crisis, April – December 2020* (Cox's Bazar, 2020b). Available [here](#) (accessed 13 November 2020); Government of The People's Republic of Bangladesh, Office of the Refugee Relief and Repatriation Commissioner, *Restricted Programme in Light of Covid-19* (Letter No-749) (Cox's Bazar, 2020). Available [here](#) (accessed 13 November 2020).

The J-MSNA targeted all Rohingya refugee households residing in the 34 camps in Ukhiya and Teknaf Upazilas. Sectors covered included Food Security, WASH, Shelter and Non-food items (NFIs), Site Management and Site Development (SMSD), Protection, including the Child Protection and Gender-Based Violence Sub-Sectors, Health, Education, Nutrition, and Communication with Communities (CwC). Both quantitative and qualitative data was collected. For the quantitative component, households were sampled from the UNHCR refugee registration database, using a stratified probability-proportional-to-size (PPS) random sampling approach, with stratification at the upazila level and a PPS sampling approach at the camp level and by gender of respondent. Results are representative of the population included in the sampling frame, i.e. households registered with phone numbers in the UNHCR refugee registration database and in areas with mobile reception, at the upazila level at a 95% confidence level and with a 5% margin of error. A total of 836 interviews were carried out between 27 July and 12 August 2020. Basic descriptive analysis was conducted, complemented by testing for statistically significant differences in outcomes between households of different socio-economic characteristics, and a comparison of 2019 and 2020 results, where possible. Qualitative key informant interviews (KIIs) were used to supplement quantitative data collection, contextualise and validate findings, and draw qualitative links between sectoral outcomes. A total of 40 KIIs were conducted with members of youth, women, and elderly committees, imams, block and deputy block leaders between 20 and 27 August 2020.

Both quantitative and qualitative data collection was conducted remotely over the phone. This limited the type and quantity of information that could be collected and therefore the depth of analysis, and put constraints on the populations that could be included in the sampling frame. While the KIIs and a secondary data review as well as the sampling approach allowed to mitigate the impact of those constraints, results should be interpreted cognisant of possible gaps and biases, for instance resulting from the exclusion of sensitive topics from the household survey, phone ownership being slightly biased towards men and better educated households, as well as mobile reception being unequal across camps. Lastly, while current levels of need have to be explained within the context of the COVID-19 outbreak and associated containment measures, it was beyond the scope of this assessment to analyse expected levels of need if the containment measures had not been put into place. The findings are therefore intended as an overview of existing levels of need and not as an evaluation of the lockdown or COVID-19 containment measures.

## Key findings

COVID-19 containment measures **severely disrupted aid and limited access to self-reliance activities and cash** among the highly aid-dependent refugee households. Compared to 2019,<sup>7</sup> the outbreak and associated containment measures particularly increased needs related to food security, health-seeking behaviour, education and (child) protection. At the same time, households' capacities to meet their needs and cope with service gaps, including recurring ones, such as monsoon-induced shelter damage, have been considerably reduced. As a result, **households are increasingly turning towards more extreme coping strategies**. If not reversed, this can be expected to have long-term negative repercussions on household and individual well-being, with those that were already most vulnerable pre-COVID-19 likely to continue to also be most negatively affected by its secondary impacts.

**Needs prioritised by households included shelter materials (reported by 63% of households among their top three priority needs), access to food (60%), and access to income-generating activities (IGAs) (41%).** Compared

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<sup>7</sup> ISCG, 2019.

to 2019,<sup>8</sup> especially the proportions of households considering shelter materials and IGAs priority needs (47% and 22% in 2019) increased considerably, likely reflective of the impact of the COVID-19 outbreak on access to cash as well as subsequently the ability to access shelter materials independently. Households with female respondents in particular also prioritised access to safe and functional latrines, as well as electricity.

Within the constraints of the COVID-19 containment measures, for a few services coverage remained widespread. **Many service gaps, however, that had already existed pre-COVID-19 also remained.**

**The majority of households (69%) reportedly faced issues with their shelter.** While the occurrence of shelter issues as such was not directly impacted by the COVID-19 outbreak, **limited and delayed assistance meant that they were less easily resolved.** Both shelters and the wider camp environment also continue to be characterised by a lack of light, which was reported by 58% of households. This likely exacerbates **protection risks**, in particular for women and girls, and prevents households from conducting basic activities after dark. In addition, waste remains a problem in camps, with 27% of households reporting often or always having found visible waste in the vicinity of their shelters in the 30 days prior to data collection.

Likely as a result of a **reduced diversity of food assistance** and the **disruption of different types of self-reliance activities and cash assistance**, Food Consumption Scores (FCS), related to supplementary feeding programming, worsened during the COVID-19 pandemic. Specifically, the proportion of households with a poor FCS increased from 5% in 2019 to 15% in 2020, while the proportion of households with an acceptable FCS dropped from 54% in 2019 to 35% in 2020.<sup>9</sup> Increased **challenges in updating registration information** as a result of a reduction in human resources to resolve registration issues and update assistance cards following the COVID-19 outbreak likely aggravated access to food assistance for households having moved camps during the lockdown. Overall, a very high proportion of households reported having adopted **food-based coping strategies** in the seven days prior to data collection due to a lack of food (71%), a further indication of potential **food shortages and consumption gaps.**

In addition, **overall health outcomes may have been negatively affected by the impact of the COVID-19 outbreak on health-seeking behaviour**, with the proportion of individuals reported sick enough to require medical treatment having dropped from 35% in 2019<sup>10</sup> to 9% in 2020. This is likely reflecting a drop in the proportion of individuals that sought treatment when they should have, and thus a reduction in health-seeking behaviour.

Moreover, **40% of children aged 6 to 59 months were reportedly not enrolled in nutrition-feeding programmes**, with a **lack of effective communication and awareness** of such programmes and their benefits possibly being one explanatory factor.<sup>11</sup>

**Education enrolment, in particular among adolescents, and especially adolescent girls, also remained low.** The longer temporary learning centres (TLCs) continue to be closed in line with COVID-19 containment measures, the more likely this gap is to increase, with secondary data indicating the potential long-term impacts of the closure of

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<sup>8</sup> ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA), Rohingya Refugees, Cox's Bazar, Bangladesh, September 2019* (Cox's Bazar, 2019). Available [here](#) (accessed 13 November 2020).

<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Enrolment rates in nutrition-feeding programmes in camps are expected to be high, as programmes admit both malnourished and well-nourished children/PLWs.

learning facilities to be very concerning, including that the longer children, especially girls, are out of school, the less likely they are to return.<sup>12</sup>

The **loss of access to education services as a result of the COVID-19 outbreak** generally constituted a major concern to households and key informants (KIs). On the one hand, the majority of households (62%) reported having faced challenges in supporting their children studying at home, **limiting the effectiveness of such remote study**. On the other hand, disrupted daily routines and access to TLCs also led to concerns about children's well-being among KIs, while households reported an **increase in child protection issues** in their communities, most notably in child labour and children going missing, both reported to have increased in communities by 16% of households. Impacts of exacerbated protection risks may have been further compounded by the **limited presence of protection actors** in camps following the enactment of COVID-19 containment measures.

Exacerbated needs, coupled with reduced access to self-reliance activities, cash and other forms of assistance led to an **erosion of coping capacities**. As households were not able anymore to rely on previously common coping strategies, such as borrowing money, selling assistance and buying items on credit due to a lack of cash and assistance in camps, an **increasing proportion of households adopted crisis-level coping strategies**, while simultaneously **reducing assets and savings**. Such an erosion of coping capacities will likely render households **more vulnerable to future shocks** as well as a possibly continued disruption of assistance and lack of access to livelihood opportunities. It can further be expected to have **negative repercussions on health, food security and nutrition as well as household exposure to extreme protection risks**.

**Households that were more vulnerable pre-COVID-19 are likely to also have been most vulnerable to the secondary impacts of the COVID-19 outbreak**, including female-headed households or households without a working-age or adult male, households with persons with disability (PWDs), and large households or households with high dependency ratios. Both **households without adult males** and **households with PWDs** were found to be **significantly more likely to report having adopted food-based coping strategies** in the seven days prior to data collection due to a lack of food. In addition, **households without adult males were significantly more likely to report having lost access to basic services following the COVID-19 outbreak**. Results further indicate **largely female households having had less contact with humanitarian actors**, with potentially negative effects on the degree to which their specific needs are reflected in the design of assistance programmes.

**Household satisfaction with assistance since the COVID-19 outbreak decreased most for assistance on education, shelter, food, site management, health care and nutrition**. The proportion of households reporting those types of assistance having gone well decreased by 12 (nutrition) to 34 (education) percentage points since the initiation of COVID-19 containment measures. At the same time, **greatest information needs exist around livelihoods, shelter/NFIs, education and nutrition assistance**, with 37% to 78% of households reporting not having received enough information on those types of services. The latter possibly reflects uncertainty about households' continued access to those services now and in the future and households' desire to receive clear information on this, as those services were all scaled down in line with COVID-19 containment measures.

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<sup>12</sup> United Nations Sustainable Development Group (UNSDG), *Policy Brief: Education during COVID-19 and beyond* (New York, 2020). Available [here](#) (accessed 13 November 2020); The Economist, *School closures in poor countries could be devastating* (Johannesburg, Paris and Sao Paulo, 2020). Available [here](#) (accessed 13 November 2020); The World Bank, *Simulating the Potential Impacts of the COVID-19 School Closures on Schooling and Learning Outcomes: A set of Global estimates* (online, 2020). Available [here](#) (accessed 13 November 2020).

Given the exacerbated needs and the severe erosion of coping capacities, as well as the quickly changing levels of need that can be expected as the pandemic evolves and humanitarian programming continues to be adapted, in the near and medium term, it will be of great importance to continue to **closely monitor needs and service gaps** to allow for continued evidence-based programming. Moreover, **additional information on the impact of the lockdown on levels of security, protection-related incidents and their impacts on household and individual well-being** is required to be able to effectively counter negative trends. Furthermore, a **better understanding of the impacts of the COVID-19 outbreak and associated containment measures on the most vulnerable households** may help more effectively alleviate those. Both will require restored access to camps and carefully designed in-person data collection. In the long term and in the context of future MSNAs, a **more comprehensive assessment of key barriers to accessing different types of services faced by different groups of households and individuals** may contribute to reducing persisting vulnerabilities in the long run.

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## List of Acronyms

|                 |   |
|-----------------|---|
| <b>AAP</b>      | Accountability to Affected Populations  |
| <b>CiC</b>      | Camp-in-charge  |
| <b>COVID-19</b> | Coronavirus Disease 2019  |
| <b>CwC</b>      | Communication with Communities  |
| <b>DAP</b>      | Data analysis plan  |
| <b>DC</b>       | Deputy Commissioner   |
| <b>ECHO</b>     | Directorate-General for European Civil Protection and Humanitarian Aid Operations |
| <b>FCN</b>      | Family Counting Number  |
| <b>FCS</b>      | Food Consumption Score  |
| <b>GBV</b>      | Gender-based violence   |
| <b>IGA</b>      | Income-generating activity  |
| <b>IMAWG</b>    | Information Management and Assessment Working Group                               |
| <b>ISCG</b>     | Inter Sector Coordination Group   |
| <b>IOM NPM</b>  | International Organization for Migration Needs and Population Monitoring          |
| <b>J-MSNA</b>   | Joint Multi-Sector Needs Assessment   |
| <b>JRP</b>      | Joint Response Plan   |
| <b>KI</b>       | Key informant   |
| <b>KII</b>      | Key informant interview   |
| <b>LPG</b>      | Liquefied petroleum gas   |
| <b>NFI</b>      | Non-Food Item   |
| <b>NGO</b>      | Non-Governmental Organisation   |
| <b>PLW</b>      | Pregnant/lactating women  |
| <b>PPS</b>      | Probability-proportional-to-size  |
| <b>PSEA</b>     | Protection against sexual exploitation and abuse                                  |
| <b>PWD</b>      | Person with disability  |
| <b>RRRC</b>     | Refugee Relief and Repatriation Commissioner                                      |
| <b>SDR</b>      | Secondary data reports  |
| <b>SEG</b>      | Strategic Executive Group   |
| <b>SGBV</b>     | Sexual and gender-based violence  |
| <b>SMSD</b>     | Site Management and Site Development  |
| <b>SOP</b>      | Standard Operating Procedure  |
| <b>TLC</b>      | Temporary Learning Centre   |
| <b>TWB</b>      | Translators Without Borders   |
| <b>TWG</b>      | Technical Working Group   |
| <b>UNHCR</b>    | United Nations High Commissioner for Refugees                                     |
| <b>UNO</b>      | Upazila Nirbahi Officer   |
| <b>WASH</b>     | Water, Sanitation and Hygiene   |
| <b>WFS</b>      | Women-friendly spaces   |
| <b>WFP</b>      | World Food Programme  |

## Geographical Classifications

|                 |   |
|-----------------|---|
| <b>District</b> | Third tier of administration in Bangladesh, forming sub-units of divisions  |
| <b>Upazila</b>  | Fourth tier of administration in Bangladesh, forming sub-units of districts |

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## INTRODUCTION

Over the last four decades, Rohingya refugees have been fleeing in successive waves to Bangladesh from Rakhine State, Myanmar. Periodic outbreaks of violence led to large exoduses of refugees in particular in 1978, between 1991 and 1992, and in other short waves prior to August 2017.<sup>13</sup> Since August 2017, an estimated 745,000 Rohingya refugees have fled to Cox's Bazar District, Bangladesh, where approximately 860,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas.<sup>14</sup>

Already prior to displacement, the Rohingya faced challenges accessing basic services and meeting basic needs in Myanmar.<sup>15</sup> This is reflected in factors such as low educational attainment among the Rohingya refugees in Bangladesh both in absolute terms, and relative to the average in Myanmar.<sup>16</sup> Poverty in Rakhine State, where the Rohingya constituted one-third of the population prior to the 2017 mass exodus, is nearly twice the national average of Myanmar, with households' levels of poverty likely having been further exacerbated during migration. High numbers of refugee children had never received any vaccinations in Myanmar, and recorded levels of acute malnutrition, child and maternal mortality in Rakhine State are all indicative of gaps in health outcomes among the population.<sup>17</sup>

The Rohingya population in camps is highly reliant on humanitarian assistance. While the situation has stabilised and all refugees continue to receive humanitarian assistance, a lack of access to regular income and livelihood opportunities continues to be a major impediment towards higher degrees of self-reliance. Poor diets, a lack of formal education, insufficient health as well as water, sanitation and hygiene (WASH) provisions remain challenges,<sup>18</sup> and weak shelter structures leave the refugees vulnerable to the impacts of the recurring cyclone seasons that destroy thousands of shelters each year.<sup>19</sup>

With the Rohingya unlikely to return to Myanmar in the near or medium term<sup>20</sup>, and the response having moved beyond the initial emergency phase, comprehensive information on the needs and vulnerabilities of all affected populations is needed in order to inform the design and implementation of effective inter-sectoral programming. Moreover, the high fluidity of population movements, changing services within each settlement, and the challenges presented by the monsoon and cyclone seasons require regularly updated analyses of household needs and access to services.

At the same time, the global COVID-19 pandemic and associated containment measures severely restricted access and service delivery to the highly aid-dependent refugee communities throughout much of 2020, with humanitarian operations in camps having moved to essential services only from 24 March 2020.<sup>21</sup> An understanding of household-

<sup>13</sup> Zakaria, F. (2019), "Religion, mass violence, and illiberal regimes: Recent research on the Rohingya in Myanmar", *Journal of Current Southeast Asian Affairs*, 38(1), pp. 98 – 111.

<sup>14</sup> Inter Sector Coordination Group (ISCG), *Situation Report Rohingya Refugee Crisis, Cox's Bazar, Bangladesh, June 2020* (Cox's Bazar, 2020a). Available [here](#) (accessed 13 November 2020).

<sup>15</sup> Rosenthal, G., *A brief and independent inquiry into the involvement of the United Nations in Myanmar from 2010 to 2018* (May 2019). Available [here](#) (accessed 13 November 2020).

<sup>16</sup> Davis, A. et al., *Socioeconomic Characteristics of Rohingya Refugees from Myanmar living in Bangladesh, April 2020* (Washington, D.C. 2020). Available [here](#) (accessed 13 November 2020).

<sup>17</sup> Abishek, B. et al. (2018), "The Rohingya in Cox's Bazar: When the Stateless Seek Refuge", *Health and human rights* 20(2), 105.

<sup>18</sup> World Food Programme (WFP), *Refugee influx emergency vulnerability assessment (REVA) – Cox's Bazar, Bangladesh (April 2020)* (Cox's Bazar, 2020a). Available [here](#) (accessed 13 November 2020).

<sup>19</sup> International Crisis Group (ICG), *A Sustainable Policy for Rohingya Refugees in Bangladesh*, Asia Report N°303, 27 December 2019 (Brussels, 2019). Available [here](#) (accessed 13 November 2020).

<sup>20</sup> Ibid.

<sup>21</sup> ISCG, *2020 COVID-19 Response Plan, Addendum to the Joint Response Plan 2020, Rohingya Humanitarian Crisis, April – December 2020* (Cox's Bazar, 2020b). Available [here](#) (accessed 13 November 2020).



level multi-sectoral needs, capacities and access to services within the context of the COVID-19 containment measures will therefore be essential for a full understanding of priority needs for 2021.

Against this background, a Joint Multi-Sector Needs Assessment (J-MSNA) was conducted across Rohingya refugee populations to support detailed humanitarian planning and enhance the ability of operational partners to meet the strategic aims of donors and coordinating bodies. The general objective of the J-MSNA was to inform evidence-based strategic planning of humanitarian response activities by the Strategic Executive Group (SEG), the Inter Sector Coordination Group (ISCG) Secretariat, sectors, and sector partners, through the provision of up-to-date, relevant and comparable information on the multi-sectoral needs of refugee populations in Cox's Bazar District.

The 2020 J-MSNA built on previous MSNAs, most notably the [2019 J-MSNA](#), with the aim to facilitate an understanding of the evolution of needs and service gaps across time, where possible. It was implemented through the ISCG's MSNA Technical Working Group (TWG) of the Information Management and Assessment Working Group (IMAWG), which is led by the ISCG and comprised of the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration Needs and Population Monitoring (IOM NPM), ACAPS, and REACH. Translators without Borders (TWB) provided additional technical support. Sectors were actively involved in research design, preparations for data collection, and the discussion of results and analyses.

In the following chapter, the specific objectives of the assessment and the research questions will be introduced. The scope of the assessment and the methodology will be outlined, including the sampling strategy, data collection parameters, data analysis and secondary data review. Moreover, ethical considerations, and challenges and limitations will be highlighted. Thereafter, findings will be presented, with a focus on needs and service gaps within the context of COVID-19 containment measures. The findings section will conclude with a summary of results related to Accountability to Affected Populations (AAP). The report will then close with a concluding summary and outlook.

## METHODOLOGY

### Specific objectives and research questions

Aiming to expand the body of analysis and address key information gaps by providing an accurate snapshot of the situation, the 2020 J-MSNA was conducted with the specific objectives to:

1. Provide a comprehensive evidence base of the diverse multi-sectoral needs among refugee populations to inform the 2021 Joint Response Plan (JRP);<sup>22</sup>
2. Provide an analysis of how refugee population needs have changed in 2020 with an emphasis on the impact of the COVID-19 pandemic on multi-sectoral needs;
3. Provide the basis for a joint multi-stakeholder analysis process.

To this end, the J-MSNA sought to answer the following research questions:

1. What are the needs and service gaps within refugee camps?
2. What are the characteristics of households most in need?
3. What are the immediate and structural factors associated with these needs?
4. To what extent have these needs and service gaps been impacted by the COVID-19 pandemic?
5. What behaviours and coping strategies are households undertaking in order to meet their needs, in particular in view of the COVID-19 crisis, and what factors influence these behaviours?
6. What are households' perspectives on aid delivery, as well as their preferences, and priorities with regards to aid delivery for 2021?

### Scope and tool development

In line with the geographical coverage and population targeted by both the previous and the 2021 JRP, the assessment targeted all Rohingya refugee households residing in the 34 camps in Ukhiya and Teknaf Upazilas. Sectors covered included Food Security, WASH, Shelter and Non-food items (NFIs), Site Management and Site Development (SMSD), Protection, including the Child Protection and Gender-Based Violence Sub-Sectors, Health, Education, Nutrition and Communication with Communities (CwC). All sectors as well as the Gender Hub were consulted during tool design. Both quantitative and qualitative data collection was conducted.

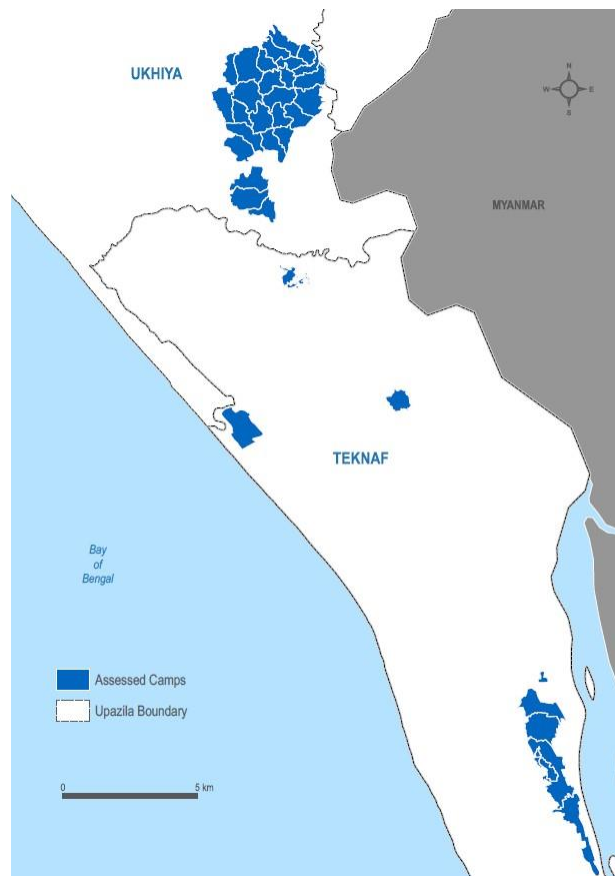
#### *Quantitative component*

For the quantitative household survey, the 2019 J-MSNA tool and indicators were reviewed and adaptations to the current context discussed during a first round of consultations with sectors. The MSNA TWG then developed a preliminary version of the 2020 J-MSNA questionnaire. As interviews had to be conducted remotely over the phone, however, questionnaire length had to be limited. Therefore, in a second step, sectors prioritised the indicators included in the preliminary version of the tool, which was subsequently finalised by the MSNA TWG giving priority to questions as indicated by sectors. The tool was translated to Rohingya prior to enumerator training and data collection.

<sup>22</sup> A separate J-MSNA with the same objectives was simultaneously conducted in the host community.

### Qualitative component

For the semi-structured key informant interviews (KIIs), the MSNA TWG, guided by the research questions least addressed by the quantitative tool, proposed topics and questions for inclusion to sectors. Sectors then revised and also prioritised the questions. The KII tool was subsequently finalised by the MSNA TWG based on sector feedback. It was translated to Rohingya prior to enumerator training and data collection. The tool was structured into a section on CwC and AAP, and seven sectoral sections. Due to time constraints, each key informant (KI) was to be interviewed on CwC and AAP as well as two sectors of his/her choice, reflecting the sectors for which the KI thought assistance was generally hardest to access, had become significantly harder to access since the lockdown and/or represented the most urgent needs/biggest service gaps since the lockdown.



**Map 1** Assessed camps in Ukhiya and Teknaf Upazilas, Cox's Bazar

## Sampling strategy

### Quantitative component

Households, defined as a group of people living together, and generally eating from one pot (sharing food), were the unit of measurement for this assessment. Target sample sizes were based on the most recent population figures available from UNHCR. Households were sampled from the UNHCR refugee registration database, including all

registered refugee households, using a stratified probability-proportional-to-size (PPS) random sampling approach with the aim of generating results representative at the upazila level at a 95% confidence level and with a 5% margin of error. The sample was stratified at the upazila level, with sample sizes at the camp level being proportional to camp population sizes. Moreover, as phone ownership was known to be more prevalent among men, in order to ensure adequate representation of female respondents, female-headed households were sampled proportionately to their representation in the database. Only households registered with phone numbers could be included in the sampling frame. Furthermore, households in areas with little or no phone connection could not be reached.

An estimated buffer was included into all sample size calculations to account for (1) non-eligible households, such as Bangladeshi households living within camp boundaries and vice versa; (2) non-response, including non-functional phone numbers, households without mobile reception, or switched off phones; (3) non-consenting households, including households not consenting to or not finishing the survey; (4) households without an appropriate respondent, including all households without a consenting individual aged 18 and above; and (5) data cleaning/errors, including completed surveys that would be removed during data cleaning and therefore not be part of the final sample.

The interviews were conducted with the person answering the phone, usually expected to be the head of household, provided that consent was given and the respondent was aged 18 or above. The enumerator teams were composed of roughly equal numbers of male and female enumerators. While female enumerators could interview respondents of either gender, male enumerators were instructed to only interview male respondents, and agree on a time with female respondents for a female enumerator to call them back. Overall, 23% of respondents were female and 77% of respondents were male. Eighty-six percent (86%) of female respondents and 8% of male respondents reported having replied on behalf of a female-headed household, with the remaining respondents having replied on behalf of male-headed households.

#### *Qualitative component*

For the KIIs, a total of one to two interviews per camp was targeted. KIIs were purposively sampled and included members of youth, women, and elderly committees, imams, block and deputy block leaders.

## Data collection

#### *Quantitative component*

Quantitative data collection took place between 27 July and 12 August 2020. A total of 836 households, composed of 4,293 individuals, were surveyed across all 34 refugee camps.<sup>23</sup> This included 387 households from camps in Teknaf, and 449 households from camps in Ukhiya. Results are therefore representative at the upazila level of all refugee households included in the sampling frame, i.e. households with phones and mobile reception, at a 95% confidence level and with a 5% margin of error. They can further serve as a proxy of the entire camp population in Teknaf and Ukhiya. Data collection was led by REACH and data collected by 3 teams of UNHCR enumerators, consisting of 9 to 11 enumerators each (31 enumerators in total).

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<sup>23</sup> A full list of completed interviews by camp is included in annex 1.



Prior to data collection, enumerators underwent a four-day online training to familiarise themselves with the tool and data collection protocols.<sup>24</sup> Sector representatives facilitated training sessions on the questionnaire sections pertaining to their sectors to ensure that the intent and wording of each question was well understood. The tool and data collection protocols were piloted with a sample of refugee households during a two-day remote piloting exercise to identify and rectify problems before the full roll-out of data collection. Following the piloting, the tool was further refined based on lessons learnt during the pilot related to phrasing/understanding of the questions by both the enumerators and the respondents, displaying/sequencing of questions on the screen or missing response options.

During the interviews, data was entered directly into tablets using the KoBoCollect software. At the end of each day, surveys were uploaded to the UNHCR server, where raw data was accessible only to one individual within REACH. Data was checked and cleaned on a daily basis according to a set of pre-established Standard Operating Procedures (SoPs) in line with defined minimum standards, including outlier checks, the correct categorisation of “other” responses, the identification and removal or replacement of incomplete, inaccurate or incoherent records, and the recoding and standardisation of entries. All changes to the data were documented in a data cleaning log. Based on observations during the pilot, 20 minutes was established as the minimum length of the interview required to ensure an acceptable level of data quality. Any interviews falling below this threshold were excluded from the final dataset. Moreover, each respondent in the sample was allocated an ID, based on which and together with information on Family Counting Numbers (FCN) and location (camp and block numbers), where provided, it was attempted to verify that the correct households had been interviewed. In total, 14 of 850 completed interviews were deleted from the final dataset due to quality issues related to timing or duplicate respondent IDs that could not be corrected.

### *Qualitative component*

Qualitative data collection took place between 20 and 27 August 2020. A total of 40 KIs were interviewed, including 28 male and 12 female KIs.<sup>25</sup> The sectoral sections of the questionnaire were discussed by a minimum of 5 (Protection) and a maximum of 16 (Health), or an average of 11 KIs each. Given this limited number of interviews per sector, while serving as a basis for the contextualisation and validation of quantitative findings, results should be interpreted cognisant of the fact that data saturation was likely not reached.

Data collection was led and conducted by REACH with a team of nine enumerators. Prior to data collection, enumerators underwent a one-day online training to familiarise themselves with the tool, and data collection protocols. The training included practice sessions to test the phrasing and understanding of the questions. Following the training and prior to the start of data collection, the tool was finalised based on enumerator feedback during the training.

As the interviews were conducted remotely over the phone, they were recorded and the recordings used as a basis for transcription and analysis.

## Data analysis

Results were analysed by sector. The requirement to limit questionnaire length also imposed constraints on the types of analysis that could meaningfully be conducted. As such, no comprehensive quantitative inter-sectoral analysis was carried out. The estimation of the proportion of households in need and corresponding caseloads was also beyond the

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<sup>24</sup> The enumerator training agenda is included in annex 3.

<sup>25</sup> A full list of completed KIs is included in annex 2.

scope of this assessment. However, qualitative results and the secondary data review provide a foundation, based on which qualitative links between sectoral outcomes could be drawn and a more holistic picture of needs and service gaps be provided. Lastly, while current levels of need have to be explained within the context of the COVID-19 outbreak and associated containment measures, it was beyond the scope of this assessment to analyse expected levels of need if the containment measures had not been put into place. The findings are therefore intended as an overview of existing levels of need and not as an evaluation of the lockdown or COVID-19 containment measures.

#### *Quantitative component*

A basic data analysis plan (DAP) was drafted, outlining stratifications, additional composite indicators to be constructed and the basic descriptive statistics to be calculated for each indicator. The DAP was reviewed by sectors and finalised by the MSNA TWG based on sector inputs. To account for the unequal distribution of households across the two upazilas, results were weighted at the camp level during the basic descriptive analysis.

Secondly, based on sector characterisations of vulnerable households, the MSNA TWG identified a range of indicators, for which the existence of statistically significant differences in outcomes between households of different socio-economic characteristics was tested. Pearson's chi-square test of independence was used to determine whether or not there was an association between the household characteristics and indicator outcomes. Relationships were determined to be statistically significant for  $p$ -values  $\leq 0.05$ . For tests involving more than two distinct groups of households across a certain characteristic, if a significant difference was generally found to exist between the groups, a post-hoc analysis based on the residuals of the chi-square test was conducted to determine the group(s) driving the significant difference. Data was further analysed by upazila, and by gender of respondent for indicators for which differences in perceptions between male and female respondents were expected. Moreover, basic statistics were calculated disaggregated by the gender of the head of household as well as by the presence or absence of adult males in households. The latter was expected to serve as a proxy of female-headed households with a female person also being the main decision-maker in the household. For selected indicators, the existence of statistically significant differences between upazilas, households with male and female respondents, and households with and without adult males was tested.

Lastly, in cases in which indicators were comparable, 2020 J-MSNA results were compared to 2019 J-MSNA results. No statistical significance testing was conducted for 2019 to 2020 comparisons because of very different sample sizes. However, large differences (typically differences of more than ten percentage points) were considered in the interpretation of the results and are presented in the following, where relevant.

Preliminary findings, including basic descriptive statistics, selected significance tests, and 2019 to 2020 comparisons, were shared with sectors. During individual sector meetings, results were further discussed, validated and opportunities for additional analyses identified.

#### *Qualitative component*

A basic DAP was drafted, outlining how the qualitative component would feed into answering the overall research questions. The DAP was reviewed by sectors and finalised by the MSNA TWG based on sector inputs. KII recordings were translated and transcribed at the end of the data collection process. With the DAP used as a starting point to

identify key themes, the translated transcripts were then processed in NVivo to draw out trends, themes, and key messages across interviews.

## Secondary data review

To support the contextualisation of the findings from the primary data collection exercise and in light of the drastic change in the situation brought about by COVID-19 and the associated containment measures, the ACAPS – NPM analysis hub produced seven brief response-level secondary data reports (SDRs) for specific sectors and working groups engaged in the MSNA process.

Each SDR focused on how the affected populations' lives had changed since the last J-MSNA in 2019 had been conducted and aimed at highlighting potential unmet needs and the specific challenges people were now facing when meeting their basic needs. These reports were developed in collaboration with the various coordination bodies and consist of publicly available secondary information as well as internal specific operational reports. The SDRs used statistically representative assessments conducted pre-COVID-19 as a baseline, and small-scale assessments and analyses, both quantitative and qualitative, that were conducted during the COVID-19 response to assess changes, gaps and challenges.

Each sector was given the opportunity to review their specific report to ensure accuracy and appropriateness before the reports were combined and shared with the MSNA TWG for analysis alongside the 2020 J-MSNA findings. Where relevant, the reviewed secondary data is integrated and referenced throughout this report.

## Ethical considerations and dissemination

During the research design, a data protection risk assessment was conducted to ensure that all necessary measures were taken to prevent harm to respondents from accidentally exposing their identities. In advance of the survey, respondents were informed of their right not to participate, not to answer specific questions or to end the interview when they wished. Informed consent was sought, received and documented at the start of each interview. Moreover, the enumerator training included dedicated training sessions on research ethics and code of conduct, including AAP, Protection from Sexual Exploitation and Abuse (PSEA), referral mechanisms and good interviewing practices. The Protection Sector was consulted during research design and during the training, in order to safeguard against exposing respondents, and in particular women, to risks as a result of the remote nature of the survey, during which privacy could not be ensured. Referral instructions and guidance were provided to all teams of enumerators.<sup>26</sup>

Following the preliminary presentation of results to sector partners, a [factsheet](#) highlighting key results was produced and disseminated to all sectors, the Cox's Bazar Deputy Commissioner (DC) and the Refugee Relief and Repatriation Commissioner (RRRC). Furthermore, key findings were shared with the DC, the Teknaf and Ukhiya Upazila Nirbahi Officers (UNOs), and the RRRC.

## Challenges and limitations

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<sup>26</sup> The referral instructions are included in annex 4.

Challenges and limitations of the assessment include:

- **Remote data collection:** Due to restrictions on movement, access to camps, and face-to-face interviews as part of the COVID-19 containment measures, all interviews were conducted over the phone. This created some challenges and limitations:
  - Given the expected poor connectivity and the lack of personal interaction during a phone interview, both quantitative and qualitative data collection tools were limited in length to avoid losing respondents' attention. Questions were prioritised and household questionnaire length was limited. Moreover, KIs always only discussed selected sections of the KII questionnaire.
  - As privacy could not be ensured during phone interviews, in order to avoid creating risks to respondents, sensitive topics were not included in the quantitative component of the assessment but rather attempted to be captured by the qualitative component and through the secondary data review.
  - As phone ownership is more prevalent among men, a lower proportion of households with female respondents were reached than might have been reached during an in-person survey. However, the sampling approach still allowed to include 23% of female respondents, with 86% of them reportedly having replied on behalf of a female-headed household.
  - Unequal phone ownership may have slightly biased results towards better educated households.
- **Data analysis:** The limits on questionnaire length and resulting constraints on the quantity of information captured as well as the remote nature of the survey constraining the types of information possible to collect also limited the possible types and depth of analysis. As such, no comprehensive quantitative inter-sectoral analysis was conducted. The estimation of the proportion of households in need and corresponding caseloads was also beyond the scope of this assessment. However, qualitative results and secondary data were used to qualitatively draw links between sectoral outcomes and obtain a more holistic picture of needs and service gaps.
- **Proxy reporting:** Data on individuals was collected by proxy from the respondent, not directly from household members themselves. Results might therefore not accurately reflect lived experiences of individual household members.
- **Subset indicators:** Findings related to a subset of the overall population, e.g. only to households with school-aged children, may have a wider margin of error, yielding results with lower precision. Any findings representative only with lower levels of precision are indicated as such throughout the report.
- **Respondent bias:** Certain indicators, such as perceived security threats, may be under- or over-reported due to the subjectivity and perceptions of respondents. For instance, respondents might have the tendency to provide what they perceive to be the “right” answer to certain questions (“social desirability bias”).
- **Perceptions:** Questions on household perceptions may not directly reflect the realities of service provision in refugee camps but only respondents' perceptions of them.
- **Limitations of household surveys:**
  - While household-level quantitative surveys seek to provide quantifiable information that can be generalised to the population of interest, the methodology is not suited to provide in-depth explanations of complex issues. Thus, questions on “how” or “why” are best suited to be explored through the accompanying qualitative component as well as triangulation with secondary data.
  - Since “households” are the unit of analysis, intra-household dynamics, for instance related to gender norms, roles, disability or age, cannot be captured. Users are reminded to supplement and triangulate household-level findings with other data sources.



- **Timing of assessment:** When interpreting the findings, users are informed that data collection was: (1) conducted following months of limited service provision due to COVID-19-related restrictions; (2) implemented during the monsoon season; and (3) included the festival of *Eid-al-Adha*.

## FINDINGS

### Priority needs

The most commonly reported priority needs included shelter materials, access to food, access to income-generating activities (IGAs), access to safe and functional latrines, and electricity. Access to safe and functional latrines, and electricity, were particularly important to households with female respondents, while households with male respondents more frequently identified access to food as one of their top three priority needs (Figure 1). Compared to 2019,<sup>27</sup> especially the proportion of households considering shelter materials and IGAs priority needs (47% and 22% in 2019) increased considerably, likely reflective of the impact of the COVID-19 outbreak on access to cash as well as subsequently the ability to access shelter materials independently.

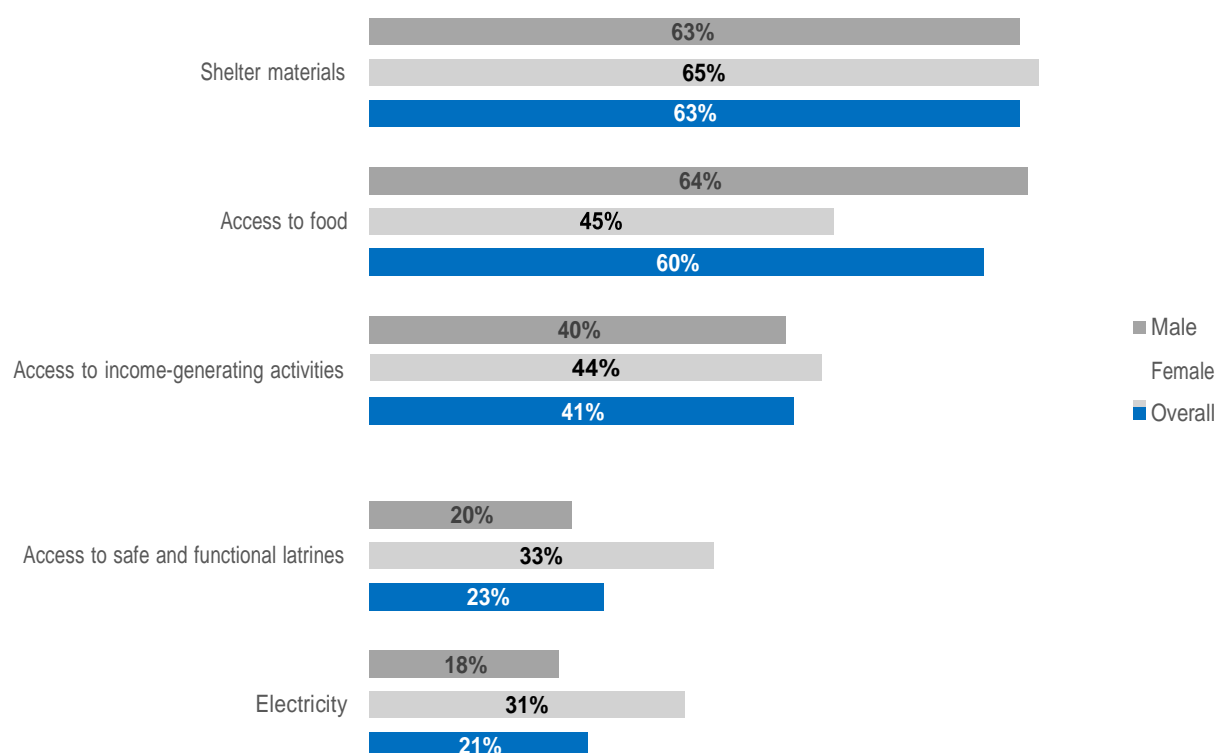


Figure 1 % of households reporting priority needs, overall and by gender of respondent (top 5)<sup>28</sup>

Generally a higher proportion of households reported preferring in-kind assistance than reported preferring cash assistance (Figure 2). However, households with female respondents more frequently reported cash assistance as their preferred modality for food (52%) compared to households with male respondents (38%), who more frequently reported in-kind assistance as their preference (48%) than households with female respondents (35%).<sup>29</sup> Additionally, another 13% of households reported preferring labour support as shelter assistance, also more frequently reported by

<sup>27</sup> ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA), Rohingya Refugees, Cox's Bazar, Bangladesh, September 2019* (Cox's Bazar, 2019). Available [here](#) (accessed 13 November 2020).

<sup>28</sup> Results for households with female respondents are representative with a +/-7% margin of error (n = 211). Respondents were asked to identify the top three priority needs.

<sup>29</sup> Results for households with female respondents are representative with a +/-11% margin of error (n = 95).

households with female respondents (29%)<sup>30</sup> compared to households with male respondents (9%), and 10% of households reported vouchers as their preferred modality to receive household/cooking items.

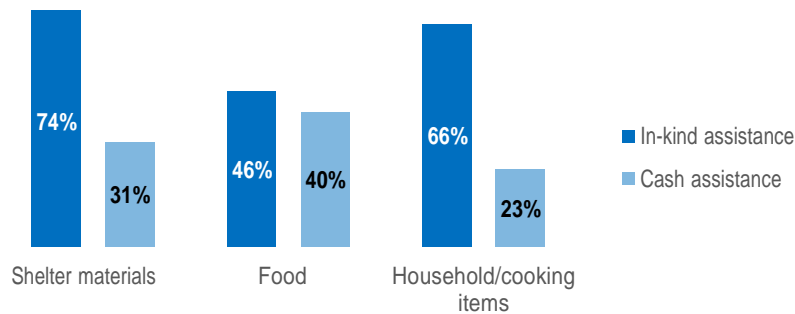


Figure 2 % of households reporting preferred modality to receive assistance<sup>31</sup>

## Needs and service gaps

### Services that continued with high coverage

Within the constraints of the COVID-19 containment measures, coverage of some services remained comparable to the high levels found in the 2019 J-MSNA, in particular related to fuel, water access and blanket food distributions. The proportion of households reporting having relied exclusively on liquefied petroleum gas (LPG) as a source of cooking fuel in the four weeks prior to data collection remained high at 88%. Almost all households reportedly (98%) received LPG from humanitarian actors, with only 2% of households reporting (also) having bought LPG. Firewood use remained low (Figure 3).

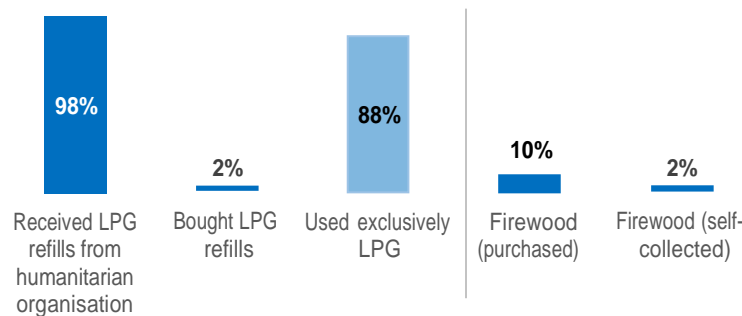


Figure 3 % of households reporting source of cooking fuel in the four weeks prior to data collection

Access to improved drinking water sources also remained high, as did the proportion of households reporting having enough water to meet domestic needs, including for drinking, cooking, personal hygiene and other domestic purposes. Less than 1% of households reported using surface water and/or unprotected springs as one of their main sources of drinking water, and 88% of households reported having enough water to meet their domestic needs. While the latter would represent a considerable increase from the 44% of households reportedly having had enough water to meet all domestic needs in 2019,<sup>32</sup> this has to be interpreted with caution. In the 2019 J-MSNA, sufficiency of water was

<sup>30</sup> Results for households with female respondents are representative with a +/-9% margin of error (n = 134).

<sup>31</sup> Respondents were asked their preferred modality to receive these items if they reported any of them as a priority need. Results for household/cooking items are representative with a +/-11% margin of error (n = 94).

<sup>32</sup> ISCG, 2019.

assessed separately for different domestic purposes, whereas in the 2020 J-MSNA, sufficiency of water was assessed simultaneously across all domestic purposes. Given that this year's question on water quantities directly followed the question on drinking water sources, it is possible that the result is partially reflective of sufficiency of drinking water rather than sufficiency of water for all domestic purposes.

For both 2019 and 2020, results on access to water have to be interpreted cognisant of the fact that data collection was conducted during the rainy season. Some KIs explicitly emphasised that households were able to access enough water at the time of data collection, only because they had access to rainwater. At the same time, they reported that water infrastructure had not been sufficiently maintained during the lockdown, limiting access to water. In addition, irrespective of water quantities, many KIs reported a lack of clean water or low water quality, requiring households to collect clean water from more distant sources.

*"Yes, they are getting clean water as needed. In this rainy season, they are collecting rainwater and filter it for drinking purposes."* – Male KI (Teknaf)

*"Due to an excessive amount of iron in the water, they can't use the tubewell water and they bring water from distant places or other blocks of the camp."* – Female KI (Ukhiya)

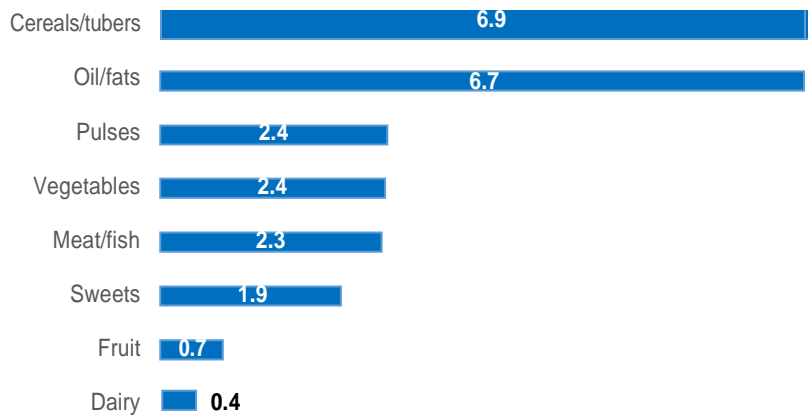
*"Previously there was regular monitoring by NGOs or the Government. They repaired the tubewells if needed, but now if a tubewell is not functioning, no one comes to repair it. As a result, people have to collect water from faraway sources."* – Female KI (Ukhiya)

Throughout the lockdown, the World Food Programme (WFP) continued to provide blanket food distributions. On the one hand, the overall calorie content was increased and the new packages designed in line with household purchasing patterns. On the other hand, however, the frequency of food distributions was reduced to mitigate the risk of COVID-19 infections and the diversity of food packages was limited – while taking preferences and nutritional requirements into consideration – due to stress on food supply chains.<sup>33</sup> At the same time, support for IGAs, such as volunteering for non-governmental organisations (NGOs), participation in cash for work programmes, and cash incentives for skill development trainings was scaled down in compliance with COVID-19 containment measures.<sup>34</sup> This severely restricted households' ability to supplement food assistance. As such, the extensive coverage of food assistance is reflected in households reporting consuming cereals and tubers almost on a daily basis, while the consumption of other food groups, with the exception of oil and fats, was very irregular, ranging from roughly every third day for pulses, vegetables, and meat and fish, to less than once a week for fruits and dairy products (Figure 4).

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<sup>33</sup> WFP, *Ensuring food assistance and safety during COVID-19*, (Cox's Bazar, 2020b). Available [here](#) (accessed 13 November 2020).

<sup>34</sup> Food Security Sector, *5W Monitoring* (Cox's Bazar, 2020).



**Figure 4** Average number of days a week households reported consuming different types of food

KIs further reported that irrespective of food quantities, the quality of the food received through assistance packages had worsened during the lockdown. However, while the qualitative data indicates that some households may have faced such issues, it does not provide any evidence on how widespread these issues were.

*“After the lockdown, the amount of food, such as rice, received through food distributions decreased. They are providing those sorts of rations we don’t like. For example, we get low quality pulses from them. We get more dry fish, which is not vital [used only as condiment]. We want to demand to get food the way we got previously from the distribution centre. Few people fall sick after eating this kind of dry fish.”*  
– Female KI (Teknaf)

*“The main problem is the ration. They used to collect different types of ration before COVID. Now they are collecting packed food, where half of the food is rotten.”* – Male KI (Teknaf)

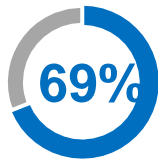
*“They are getting rations, rice from WFP, regularly and on time. But since the lockdown, they are facing problems with the rice. The quality of the rice is very poor.”* – Male KI (Ukhiya)

### *Persisting needs and service gaps*

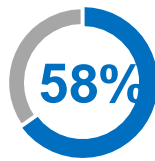
**Some needs and service gaps that had already existed pre-COVID-19 remained, in particular related to shelter/NFIs, access to education services, nutrition-feeding, waste management and the interaction of households with humanitarian actors.** As in 2019,<sup>35</sup> the proportion of households reporting issues with their shelter remained high at 69% (Figure 5). Issues with the roof were most commonly reported (by 51% of households). Moreover, 58% of households reported not having had enough light to conduct basic life activities after sunset in the six months prior to data collection (Figure 6), and 10% of households reported having had to pay rent to live in their current shelter (Figure 7)

<sup>35</sup> ISCG, 2019

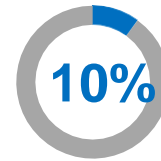




**Figure 5** % of households reporting issues with their shelter in the six months prior to data collection



**Figure 6** % of households reporting not having had enough light to conduct basic life activities after sunset in the six months prior to data collection



**Figure 7** % of households reporting having had to make rent payments to live in their current shelter in the six months prior to data collection

While shelter damage and a lack of light were issues already before the COVID-19 outbreak, households' ability to make shelter improvements or access NFIs independently has been severely reduced since the lockdown as a result of a lack of cash. This has increasingly limited households' ability to fix these issues by themselves. KIs frequently emphasised that most households had been entirely dependent on assistance to repair shelters or access NFIs.

*“Those whose shelters need repair, they collect shelter items from IOM and repair them, or they are staying in the shelter without making any improvements or repair. [...] If they don't get any help from IOM, they have to stay without repairing.” – Male KI (Ukhiya)*

*“Most people who don't have money, they don't repair the shelter but wait for the Site Management to provide shelter items for repair.” – Male KI (Ukhiya)*

*“People only rely on distributions. They don't have any other choice to get these items. Sometimes those who have a working opportunity, they could meet their needs, but most of them are suffering. [...] We are not getting enough [cooking/sleeping/lighting/household] items, so we are managing our lives without those items.” – Male KI (Ukhiya)*

Combined with the reduced presence of shelter actors in camps, this reportedly resulted in cases of shelters having been left unrepaired for extended periods of time. At the same time, records of weather-related shelter damage between July and August 2020 showed more than a 100% increase in the number of shelters damaged compared to the same period last year.<sup>36</sup> This increase in shelter damage combined with delays in repair will have increasingly constrained households to stay in damaged shelters.

*“The damage is severe now. Earlier, NGO staff came to the block regularly, observed the condition of the shelter and provided shelter materials, but since the lockdown, they are not coming and the shelter condition has not been improved.” – Female KI (Ukhiya)*

*“[Shelter is damaged] due to the monsoon, shelter damage did not increase [due to the lockdown], but since the lockdown we have seen that when our shelter was damaged, we needed to wait for a long time to repair our shelter. The shelter partners took our complaints, but when shelters needed urgent repair, they did not repair them urgently. In that case, we needed to wait for a long time to repair our shelter, which is brutal for our life.” – Male KI (Ukhiya)*

<sup>36</sup> ACAPS, IOM and Shelter Cluster, *Impact of the monsoon & COVID-19 containment measures: Shelter and infrastructure damage in the Rohingya refugee camps, Flash report – 20 August 2020* (Cox's Bazar, 2020). Available [here](#) (accessed 13 November 2020).

The reported lack of light inside and outside shelters directly impacts on other outcomes as well. For instance, households sometimes directly reported a lack of light and electricity as factors aggravating children's study at home while temporary learning centres (TLCs) were closed. Moreover, a lack of light, having been the most commonly cited reason by female respondents (50%) for feeling unsafe during the 2019 J-MSNA,<sup>37</sup> exacerbates protection risks, especially for women and girls.

Gaps also remained in access to education, in particular among adolescents, with the vast majority of individuals aged 15 and older reportedly not enrolled in TLCs. This gap is even more pronounced for girls compared to boys, with only 3% of girls aged 15 to 18 reportedly having attended TLCs for at least four days a week before the COVID-19 outbreak, compared to 28% of boys of the same age group. Education enrolment of young adults aged 19 to 24 years is extremely low for both genders – 1% for women, and 4% for men. Compared to 2019, the proportion of males aged 15 to 18 reportedly enrolled in TLCs increased from 13% to 28%. This result should be interpreted with caution, however, as it may at least in part be related to a potential bias of the 2020 J-MSNA towards slightly better educated households. Several KIs indicated the lack of study opportunities for older students as a clear barrier to accessing education for adolescents.

*“Children above the age of 12 do not want to go back to school, because all that is taught in school is the material of classes one and two, so they do not want to do those studies.” – Male KI (Teknaf)*

*“There are not enough efficient teachers, who can teach our children. Apart from this issue, our children could not study as much as they wanted. They can only get primary-level education. After that, they could not get any further education.” – Male KI (Ukhiya)*

Moreover, gaps persisted in access to or the utilisation of nutrition-feeding programmes, both for children aged 6 to 59 months and among pregnant and lactating women (PLWs). Overall, 30% of households with PLWs reported PLWs not to be enrolled in a nutrition-feeding programme,<sup>38</sup> and 40% of children aged 6 to 59 months were reported not to be enrolled.<sup>39</sup> A likely explanation is that nutrition facilities and services were scaled down and outreach was suspended in March 2020 to comply with COVID-19 containment measures,<sup>40</sup> as a result of which KIs reported reduced and more irregular nutrition support since the lockdown. This reduction in services and drop in consultations can be expected to have repercussions on health as well as potential dangerous negative implications for child development and growth.<sup>41</sup>

*“Before the lockdown we used to get four packets of cereal for a month for our children, but since the lockdown this programme was closed for two months. Now they are giving only two packets for a month.” – Female KI (Teknaf)*

*“Yes, they receive support, but it's not like before. In the past, they were provided support once a week or sometimes once every two weeks, but now, they are provided support once a month. They don't receive it as regularly as before.” – Female KI (Ukhiya)*

<sup>37</sup> ISCG, 2019.

<sup>38</sup> This question was only asked to households with PLWs. Results are representative with a 7% margin of error (n = 239).

<sup>39</sup> Enrolment rates in nutrition-feeding programmes in camps are expected to be high, as programmes admit both malnourished and well-nourished children/PLWs.

<sup>40</sup> ISCG, 2020b.

<sup>41</sup> Ibid.

In addition to reduced levels of assistance, low levels of awareness of nutrition-feeding programmes and their benefits may impede household utilisation of such programmes. While most households (70%) reported not facing issues enrolling children and/or PLWs into nutrition-feeding programmes, 10% reported not knowing what the key barriers were. This suggests a lack of awareness around nutrition assistance for a minority of households, which is further underscored by less than half the households (49%) reporting having received enough information on nutrition services since the COVID-19 outbreak (see Figure 40). Therefore, improved communication on nutrition services may help increase utilisation. This should also consider households' levels of education, as lower levels of education were found to be negatively associated with children's enrolment in nutrition-feeding programmes. Specifically, households without formal education were significantly more likely ( $p \leq 0.001$ ) and households with primary education and above significantly less likely ( $p \leq 0.01$ ) to report at least one child aged 6 to 59 months not being enrolled in a nutrition-feeding programme (Figure 8).

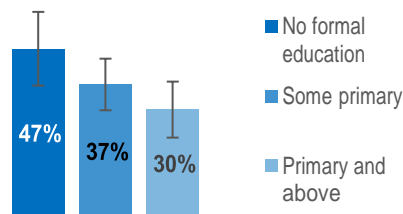


Figure 8 % of households reporting at least one child aged 6 to 59 months not enrolled in a nutrition-feeding programme<sup>42</sup>

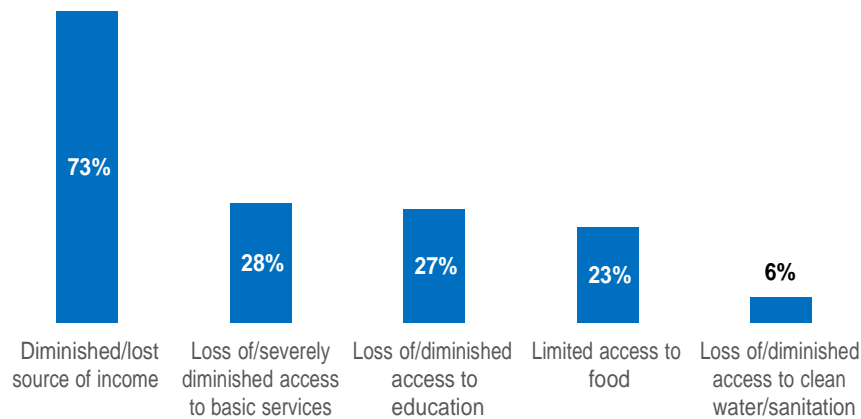
Lastly, waste management remains an issue, with 27% of households reporting often or always having found visible waste in the vicinity of their accommodation in the 30 days prior to data collection. At the same time, while 99% of households reported having increased handwashing practices since the COVID-19 outbreak, 40% of respondents were still not able to mention three critical times to wash hands,<sup>43</sup> indicating continuing gaps in hygiene awareness, possibly compounding the health impacts of a lack of a clean environment.

### Exacerbated needs and service gaps

**Other needs and service gaps were exacerbated by the lockdown, in particular those related to food security, health-seeking behaviour, education, and (child) protection and well-being.** Almost three quarters of households (73%) reported diminished/lost access to cash as an impact of the COVID-19 outbreak. In addition, roughly a quarter reported each of the following options: a loss of or diminished access to basic services (28%), a loss of or diminished access to education (27%) and/or limited access to food (23%), and 6% reported a loss of or diminished access to clean water and sanitation (Figure 9).

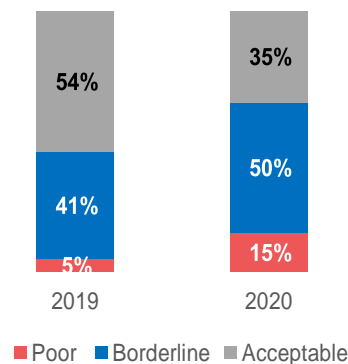
<sup>42</sup> This question was only asked about individuals aged 6 to 59 months. Results for households without formal education are representative with a +/-9% margin of error (n = 123). Results for households with some primary education (n = 194) as well as those with primary education and above (n = 192) are representative with a +/-8% margin of error. The error bars represent the 95% confidence interval for the mean value. This means that with 95% confidence the true value will be within this interval. For instance, the true value of households without formal education that have at least one child aged 6 to 59 months not enrolled in a nutrition-feeding programme is between 47% +/- 10%, i.e. between 37% and 57%. If the survey was repeated 100 times, in 95 cases, the result would be expected to be between 37% and 57% and in 5 cases it would fall outside those bounds.

<sup>43</sup> Critical times to wash hands as defined by the WASH Sector in-country include: before eating, after defecation/going to the latrine, before cooking/meal preparation, before feeding children, after handling a child's stool/changing a nappy/cleaning a child's bottom, before breastfeeding, after coming home from outside, when hands are dirty.



**Figure 9** % of households reporting impact of the COVID-19 outbreak on the household

Possibly as a result of the reduced diversity of food assistance as well as reduced household purchasing power highlighted above, Food Consumption Scores (FCS) dropped considerably compared to 2019. Specifically, the proportion of households with a poor FCS rose from 5% to 15%, while the proportion of households with an acceptable FCS dropped from 54% to 35% (Figure 10).<sup>44</sup>



**Figure 10** % of households by Food Consumption Score

As outlined above, access to IGAs was severely disrupted following the COVID-19 outbreak. Despite alternatives for self-reliance having been initiated, this resulted in a 66% drop in self-reliance interventions by Food Security Sector partners in April to August 2020 compared to the January to March 2020 period.<sup>45</sup> At the same time, the proportion of households reporting having received remittances halved from 6% to 3% compared to 2019, while the proportion of households reporting having received other cash assistance from relatives or friends reduced by two thirds from 18% to 6%.<sup>46</sup> Overall, the proportion of households without access to any form of cash – whether through self-reliance activities or from friends/relatives – increased from 4% to 30%.<sup>47</sup> This is likely a major contributor to the drop in FCS, as households without access to cash were found to be significantly more likely to have a worse FCS (Figure 11).

<sup>44</sup> ISCG, 2019.

<sup>45</sup> Food Security Sector, 2020.

<sup>46</sup> ISCG, 2019.

<sup>47</sup> Ibid.

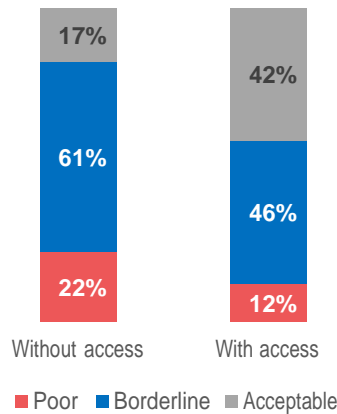


Figure 11 % of households by access to cash and FCS (p-value  $\leq 0.0001$ )<sup>48</sup>

Furthermore, households that had arrived at their shelter after February 2020 were found to have significantly worse FCS. Specifically, they were significantly more likely to have a poor FCS (p-value  $\leq 0.0001$ ) and significantly less likely to have an acceptable FCS (p-value  $\leq 0.01$ ). While this group of households was small (36 households in total), it likely comprises households that had moved between camps after February 2020 and were subsequently facing difficulties updating their assistance cards as a result of a reduction in human resources to resolve registration issues and update assistance cards following the COVID-19 outbreak. Secondary data indicates that between July and August 2020, 6% of 586 households included in two successive IOM NPM surveys faced problems accessing assistance due to being registered in another camp.<sup>49</sup> This may have left those households unable to collect their assistance with potentially severe consequence – 16 of the 36 households reportedly having arrived at their shelter after February 2020 had a poor FCS, another 17 a borderline FCS, and only 3 had an acceptable FCS – and likely leading to the adoption of negative coping mechanisms to meet food needs.

*“One of the things that has changed after the coronavirus outbreak is the delay in receiving rations. Sometimes, they are up to 15 days late. Another thing is that there were some camp residents who could not get registration. In the past, we could fix family cards, if there were any issues, but we couldn’t do it since the coronavirus outbreak.” – Male KI (Ukhiya)*

Overall, 71% of households reported having adopted food-based coping mechanisms in the seven days prior to data collection due to a lack of food, most commonly having relied on less preferred/expensive food (54%). Roughly one third of households reported having borrowed food/relied on help (34%), roughly one third reported having reduced portion sizes (34%), and roughly one quarter reported having reduced the number of meals a day (26%), all of which is likely reflective of food shortages and consumption gaps.

In addition, compared to 2019, a likely reduction in health-seeking behaviour was observed. The proportion of individuals reported sick enough to require medical treatment or to have required a regular medical check-up in the 30 days prior to data collection dropped from 35% in 2019<sup>50</sup> to 9% in 2020 (Figure 12). However, drawing from discussions

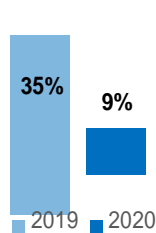
<sup>48</sup> Results for households without access to cash are representative with a +/-7% margin of error (n = 257).

<sup>49</sup> IOM, *IOM Needs and Population Monitoring, COVID-19 NPM-IVR Needs Assessment (Survey analysis: July 2020)* (Cox’s Bazar, 2020). Available [here](#) (accessed 13 November 2020); IOM, *IOM Needs and Population Monitoring, COVID-19 NPM-IVR Needs Assessment (Survey analysis: September 2020)* (Cox’s Bazar, 2020). Available [here](#) (accessed 13 November 2020).

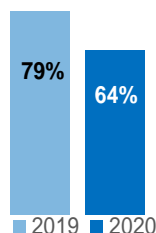
<sup>50</sup> ISCG, 2019.



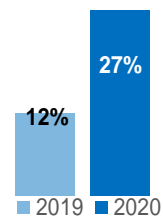
with the field team on respondents' understanding of the question and secondary data review, rather than a drop in individuals that sought or should have sought treatment, this is likely to reflect a drop in the proportion of individuals that sought treatment when they should have. This is further supported by the fact that in both years almost all individuals (97% in 2019<sup>51</sup> and 94% in 2020) reported to have required treatment were also reported to have sought treatment, indicating a tendency to only report those individuals that did seek treatment as having required treatment. At the same time, visits to NGO clinics of those seeking treatment dropped from 79% of all individuals that had sought treatment last year to 64% this year (Figure 13), while the proportion of households with an individual that required treatment/a regular medical check-up or with an individual that had died reporting having sought cheaper or lower quality treatment increased from 12% to 27% (Figure 14).<sup>52</sup> The latter likely largely includes households having sought treatment at a pharmacy or at home rather than going to a clinic. This reduction in health-seeking behaviour is most probably driven by high levels of distrust and scepticism about the quality of health services among households that already existed pre-COVID-19 and were further exacerbated following the COVID-19 outbreak. Qualitative research shows that overloaded health care systems, confidence in alternative health services outside camps, a lack of efficient communication between health staff and patients as well as a lack of accountability, and experiences in Myanmar are all reasons for this.<sup>53</sup>



**Figure 12** % of individuals reported as having had an illness serious enough to require medical treatment or to require a regular medical check-up in the 30 days prior to data collection



**Figure 13** % of individuals reported as having had an illness serious enough to require medical treatment or to require a medical check-up in the 30 days prior to data collection, for whom treatment was sought and who sought treatment at an NGO clinic<sup>54</sup>



**Figure 14** % of households with an individual having required treatment/a regular medical check-up, or an individual that had died in the 30 days prior to data collection, reporting having sought lower quality or cheaper treatment<sup>55</sup>

KIs further frequently reported low quality treatment in camps to have been an issue pre-COVID-19 that was further exacerbated following the lockdown, as consultations and treatment had become harder to access. Moreover, people were reported to have been sent away from health centres without being provided any consultation or treatment. Additionally, fear of COVID-19 and the implications of a positive test reportedly prevented people from going to hospitals at all as well as from testing for COVID-19. While previously, households who could afford it would sometimes seek better treatment outside the camps, movement restrictions had made this more difficult.

*“If anyone is suspected to have COVID, he or she is unwilling to go to the hospital. Many of the people have fear of COVID and the treatment they would get from the hospital, and have no confidence in*

<sup>51</sup> Ibid.

<sup>52</sup> Ibid.

<sup>53</sup> ACAPS, *Thematic Report: Rohingya Response, Health behaviours & COVID-19 (3 April 2020)* (Cox's Bazar, 2020). Available [here](#) (accessed 13 November 2020).

<sup>54</sup> Results are representative with +/-6% margin of error (n = 355).

<sup>55</sup> Results are representative with +/-7% margin of error (n = 222).

*better treatment. Rather they believe in doing treatment from the shelter. At least their family may take care of them.” – Female KI (Teknaf)*

*“People do not go to the hospital due to coronavirus, even though they get sick. Some people are scared. There was a rumour among the people that if anyone is found to be coronavirus positive, he or she would be taken away. [...] We also saw that some hospitals were built for corona patients with separate rooms for males and females, but still people who are suffering from fever, cough and cold don't go to the hospital out of fear, but only those who suffer from diarrhoea go to the hospital.” – Male KI (Teknaf)*

*“They [used to] go to the camp hospitals, but since the lockdown, it is difficult to get services. Hospitals refuse to treat the patients and it is hard to get medicine or treatment. Again, they were not supplied with proper medicine neither. [...] If anyone goes to the hospitals for treatment, they can't enter the hospitals, they don't get permission, they have to come back.” – Female KI (Teknaf)*

*“Doctors are not available like before. They don't check us properly and look at us from far away and they don't touch us and they just listen to us and give us medicine.” – Male KI (Ukhiya)*

*“We are not getting sufficient treatment. We need a valid document for movement. The documents we are provided do not allow us to move outside the camp and they are only valid inside the Rohingya camp area.” – Male KI (Teknaf)*

Furthermore, in line with COVID-19 containment measures, learning activities in camps were suspended in mid-March 2020.<sup>56</sup> With 20% of households with children who had attended any form of learning prior to the closure of learning facilities reporting at least one child previously having attended learning not studying remotely,<sup>57</sup> KIs voiced concerns around the impact of school closures not only on children's education but also their general well-being. One KI reported increases in child marriage as a result of school closures. Two KIs raised the potential impact of lost access to school feeding on children's well-being.

*“The children are not able to spend the time like they used to when they went to school. They sit on the street chatting and arguing with each other. The environment has become very bad.” – Male KI (Teknaf)*

*“Before COVID-19, lots of student went to the TLC. [...] Children need extracurricular activities, which are done by the learning centre, but now it is not possible, because the learning centre has closed. So, children are facing trauma and eventually they won't have any future plan neither.” – Male KI (Ukhiya)*

*“Yes, after the closure of schools, there have been adolescent girls getting married. As girls grow up, their families give their daughter for marriage.” – Female KI (Ukhiya)*

*“The children are not able to get biscuits and cannot play sports, as the school is closed.” – Male KI (Ukhiya)*

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<sup>56</sup> ISCG, 2020b.

<sup>57</sup> 591 households (71%) reported at least one child that had attended any form of learning prior to the closure of education facilities.

Secondary data indicates that the potential long-term impacts of the closure of learning facilities are very concerning, including that the longer children, especially girls, are out of school, the less likely they are to return.<sup>58</sup> This was also raised by several KIs. One KI further added that children who have started working are unlikely to go back to school. In addition, some KIs indicated older students to be less likely to go back due to the lack of learning opportunities for them outlined above.

*“Mainly women may face difficulties to go back to school, because people in the community don’t like women to go to school. As the school has closed, if they go again to school, maybe the family members will not be happy.” – Female KI (Ukhiya)*

*“Yes, some girls and some children are less likely to go back to school, because some children drop out of school and work outside to earn money and some girls have grown up, so they don't have the opportunity to go out and study anymore.” – Male KI (Ukhiya)*

While KIs reported that households who could afford it had employed home tutors to allow their children to continue studying at home, the lost education posed a major concern to most. They reported that children were not able to study effectively at home due to a lack of support, both in material terms and in terms of a lack of guidance received on remote learning, and the parents’ own lack of education.

*“Because of the lockdown children could not go to the learning centre. Most caregivers don’t have knowledge about education. So, all the children of my block rely on the learning centre. As the learning centre has closed, children could not get any education.” – Male KI (Ukhiya)*

*“Those [children] who have educated people at home are being taught a bit like before, and those who do not have educated people at home are not studying at all.” – Male KI (Ukhiya)*

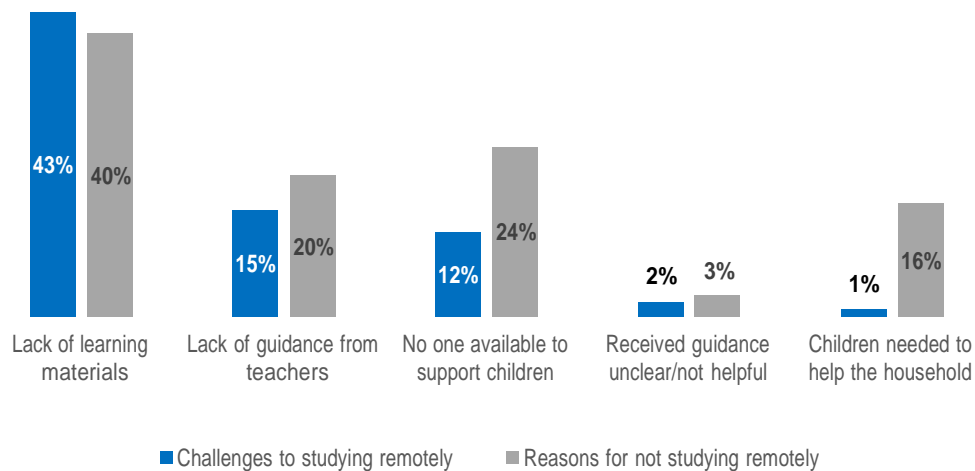
*“Students cannot learn from their teacher. They have fear of COVID and mostly they don’t have enough materials to study at home.” – Male KI (Teknaf)*

*“Mainly children from households with financial problems have fallen behind in their studies. [...] Parents who are financially strong, they can support their children to access education.” – Male KI (Teknaf)*

The majority of households (62%) reported having faced challenges in supporting their children’s remote study, with a lack of learning materials, guidance from teachers and household members available to support children having been the most commonly reported challenges or barriers to remote study (Figure 15).

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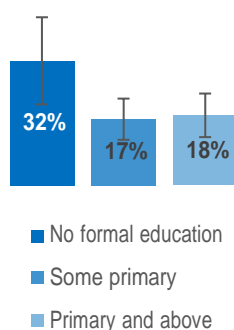
<sup>58</sup> United Nations Sustainable Development Group (UNSDG), *Policy Brief: Education during COVID-19 and beyond* (New York, 2020). Available [here](#) (accessed 13 November 2020); The Economist, *School closures in poor countries could be devastating* (Johannesburg, Paris and Sao Paulo, 2020). Available [here](#) (accessed 13 November 2020); The World Bank, *Simulating the Potential Impacts of the COVID-19 School Closures on Schooling and Learning Outcomes: A set of Global estimates* (online, 2020). Available [here](#) (accessed 13 November 2020).



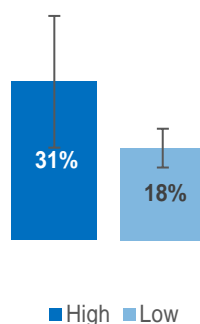
**Figure 15** % of households with children studying remotely reporting challenges (blue) and % of households with children not studying remotely reporting reasons (grey)<sup>59</sup>

A lack of learning materials and guidance from teachers seems to equally have challenged and prevented remote learning. A lack of household members able to support children and the need of children to help the household, however, appear to more frequently have completely prevented – rather than challenged – studying remotely, indicating children from least educated and most vulnerable households having been most at risk of not continuing their education at all while TLCs were closed. This is further supported by households without formal education as well as those with high dependency ratios and those without access to self-reliance/cash assistance all being significantly more likely to report at least one child not studying remotely (Figure 16, Figure 17 and Figure 18). Households with high dependency ratios were further found to be significantly more likely to report planning not to send back to its learning opportunities at least one child (p-value ≤ 0.05).

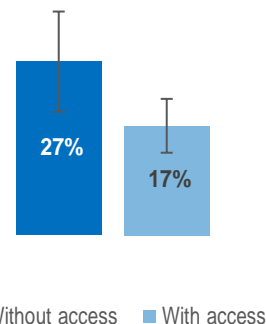
<sup>59</sup> 545 households with children that attended any form of learning before the COVID-19 outbreak reported at least one child studying remotely (80%). 121 households reported at least one child not studying remotely (20%) (the margin of error is +/-9%).



**Figure 16** % of households reporting at least one child not studying remotely by highest level of education in the household (p-value “no formal education” (post-hoc)  $\leq 0.001$ )<sup>60</sup>



**Figure 17** % of households reporting at least one child not studying remotely by dependency ratio (p-value  $\leq 0.05$ )<sup>61</sup>



**Figure 18** % of households reporting at least one child not studying remotely by access to self-reliance activities/cash assistance (p-value  $\leq 0.05$ )<sup>62</sup>

The suspension of learning activities is likely to also have contributed to an increased exposure of children to protection risks. Overall, 16% of households reported an increase in child labour in their communities as well as an increase in children going missing, 9% reported an increase in girls under 18 getting married, and 5% each reported an increase in violence against children and/or children experiencing psychosocial distress. At the same time, secondary data indicates a general increase in protection issues in camps, especially in crime and theft,<sup>63</sup> as well as an increased presence of criminal groups with heightened levels of control.<sup>64</sup> Households further reported a number of protection-related incidents, most commonly robbery, but also kidnapping, child marriage, sexual harassment or fear of sexual harassment preventing especially adolescent girls from moving freely, unofficial demands for rent payment and resulting fear of eviction, threats by local people or armed groups, *mahjees* demanding money and/or using violence against those reporting issues, and challenges related to registration, resulting in difficulties accessing assistance. At the same time, the limited presence of protection actors in camps in line with COVID-19 containment measures, including child protection and gender-based violence (GBV) actors, posed challenges in monitoring activities and effectively referring people.<sup>65</sup> Of further concern in this context is the seemingly low access to or utilisation of existing support structures, with 33% of households reporting that they would not access any type of community support structure when facing a problem. Similarly, compared to any other point-of-contact, a very large majority of households would refer a friend who had been sexually assaulted to *mahjees* (74%). This strong reliance on the *mahjee* system may sometimes be concerning, as *mahjees* have occasionally been reported to intervene violating basic protection principles. In the past, there have been allegations of corruption, favouritism, abuse of power, and inappropriate conflict

<sup>60</sup> This question was only asked to households with children and about children that had regularly attended any form of learning prior to the COVID-19 outbreak. Results for households without formal education are representative with a +/-10% margin of error (n = 97). Results for households with some primary education (n = 260) and primary education and above (n = 231) are representative with a +/-7% margin of error.

<sup>61</sup> This question was only asked to households with children and about children that had regularly attended any form of learning prior to the COVID-19 outbreak. Results for households with a high dependency ratio are representative with a +/-12% margin of error (n = 73).

<sup>62</sup> This question was only asked to households with children and about children that had regularly attended any form of learning prior to the COVID-19 outbreak. Results for households without access to cash are representative with a +/-8% margin of error (n = 164).

<sup>63</sup> IOM and ACAPS, *COVID-19 Explained: Different and Unequal: How COVID-19 affects different sex, age, ability and populations differently* (Edition 5, 27 April 2020), (Cox’s Bazar, 2020). Available [here](#) (accessed 13 November 2020).

<sup>64</sup> United Nations High Commissioner for Refugees (UNHCR), *Rohingya Refugee Response – Bangladesh, Factsheet – Protection (as of June 2020)* (Cox’s Bazar, August 2020). Available [here](#) (accessed 13 November 2020).

<sup>65</sup> IOM and ACAPS, *Impact of COVID-19 on gender programming (Thematic Report – 8 June 2020)*, (Cox’s Bazar 2020). Available [here](#) (accessed 13 November 2020).



resolution relating to the *mahjee* system, which according to secondary data may have been exacerbated by the lockdown, as *mahjees* reportedly increasingly filled gaps left by humanitarian (protection) actors in camps.<sup>66</sup>

Lastly, secondary data indicates that the drawdown of humanitarian staff in camps during the COVID-19 response meant that regular repairs and maintenance of essential infrastructure such as latrines, shelters and water points could not be completed in a timely manner.<sup>67</sup> As a result, there were increasing reports of latrines, water and bathing infrastructure not having been maintained. The decrease in functional facilities is likely to have increased pre-existing protection risks, in particular for women and girls, related to a lack of gender-segregated WASH facilities and lighting as well as facilities being located away from shelters, and to have encouraged negative coping strategies, such as delaying relief and open defecation,<sup>68</sup> all of which was echoed by KIs.

*“Latrines in the camps are not sufficient for the population. WASH providers informed us that due to a lack of space it is not possible to build new bathrooms and toilets. [...] It is not possible for different groups [of men and women] to use latrines separately, because there are too many people compared to the number of latrines. As an example, 4 latrines are allocated to 20 to 60 families. [...] Before the lockdown, cleaning was done regularly, but now nobody is taking care of it” – Male KI (Teknaf)*

*“We only have one latrine for all people on our hill. The pit of the latrine fills up within five days. Then people have to defecate on roads and open places.” – Male KI (Ukhiya)*

*“Who will we tell this and where can we have another latrine? Women just have to wait outside until the men come back from the latrine. [...] If women have to do such things, they would prefer having less food [to avoid going to the latrines], or they would go to the latrines in the evening or in the early morning wearing a burka. Usually, Rohingya women don't just go outside. Elderly women go out when needed, but it is very difficult for mature women.” – Male KI (Ukhiya)*

*“We have problems with water, as the tubewell is not functioning at all. We are bringing water from faraway places.” – Female KI (Ukhiya)*

The drawdown of humanitarian actors likely also had an impact on communication with the affected communities. While the majority of households reported having given feedback or reported complaints without problems (54%) or not having had to give feedback or report complaints (40%) in the six months prior to data collection, those that reported challenges providing feedback or complaints (6%) – with results not being representative at a 95% confidence level and with a 5% margin of error – most commonly reported that reports were not responded to or the response was not satisfactory, that they could not go out or the process was too complicated. KIs raised both delays in problem resolution and increased challenges reporting issues or obtaining assistance, e.g. to update family cards, as problems having resulted from the limited presence of humanitarian actors in camps since the lockdown.

<sup>66</sup> IOM, ACAPS and REACH, *Vulnerabilities in the Rohingya refugee camps* (Cox's Bazar, 2019). Available [here](#) (accessed 13 November 2020); UNHCR, 2020; UNHCR and REACH, *Settlement and Protection Profiling: Round 6, November 2019* (Cox's Bazar, 2020). Available [here](#) (accessed 13 November 2020); Amnesty International, *Let us speak for our rights: Human rights situation of Rohingya refugees in Bangladesh* (London, 2020). Available [here](#) (accessed 13 November 2020).

<sup>67</sup> BBC Media Action and Translators without Border (TWB), *What Matters Bulletin, June 29, 2020*. Available [here](#) (accessed 13 November 2020); UNHCR, 2020; UNHCR and REACH, 2020.

<sup>68</sup> IOM, *IOM Needs and Population Monitoring COVID-19 NPM-IVR Needs Assessment Round 2 (Survey Analysis: September 2020)* (Cox's Bazar, 2020). Available [here](#) (accessed 13 November 2020).

“Since the lockdown we have seen that NGO presence is reduced in the camps. Previously, we were able to reach the NGO offices very easily to inform of any issue. [...] Since the lockdown, we have seen a very low presence of humanitarian actors in the camps and eventually we could not reach them with our problems.” – Male KI (Ukhiya)

“Only people who know about the CiC<sup>69</sup> office, they go there. Before UNHCR staff would come here, but now they are not always available. If we need to make a change, like if there is a need to change anything with the cards, and if there is a need to update the registration information with a new baby in the family, it is a problem now. If we need to update our [family card] data, it takes eight months, one year, like this we cannot do this properly. If we go to the CiC office, then they tell us to go to the helpdesk and send us back, so people go to the helpdesk and only Allah knows, if it will work or not. Don’t know, it will take one month, two months.” – Male KI (Ukhiya)

Almost half the households reported rarely (22%) or never (25%) having been consulted on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak. In particular, households without English or Bangla speakers were significantly more likely to report rarely or never having been consulted (Figure 9). At the same time, those households were significantly more likely to report not having had to give feedback (p-value ≤ 0.01) and significantly less likely to report having faced problems doing so (p-value ≤ 0.05). The latter likely indicates that those households were less likely to try and make use of the feedback mechanism than actually being less likely to face problems, raising a need to both improve communication with and make feedback mechanisms more accessible to those households. Open communication will further be important to reverse the increasing dissatisfaction with humanitarian services, and growing frustration with inadequate feedback that negatively affected the overall perception of humanitarian actors since the lockdown.<sup>70</sup>

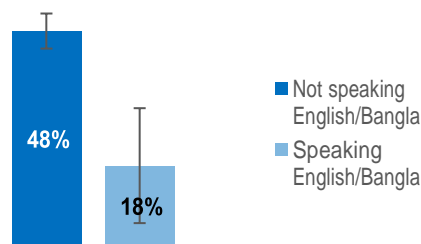


Figure 19 % of households reporting rarely or never having been consulted on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak (p-value ≤ 0.001)<sup>71</sup>

## Erosion of coping capacities

**The loss of access to self-reliance activities coupled with reduced levels of assistance and exacerbated needs led to an erosion of household coping capacities.** The adoption of less extreme coping strategies that were most

<sup>69</sup> Camp-in-charge

<sup>70</sup> Sutton, R. (Ed.), *Rohingya Experiences of Covid-19 in Cox’s Bazar Camps (PSRP Research Report: Covid-19 Series)* (Edinburgh, 2020). Available [here](#) (accessed 13 November 2020); BBC Media Action and Translators without Border (TWB), *What Matters Bulletin, June 16, 2020*. Available [here](#) (accessed 13 November 2020); IOM and ACAPS, *COVID-19 Explained: Different and Unequal (Edition 5, 27 April 2020)* (Cox’s Bazar, 2020). Available [here](#) (accessed 13 November 2020).

<sup>71</sup> Results for households speaking English/Bangla are representative with a +/-16% margin of error (n = 39).

commonly adopted last year, such as borrowing money, selling assistance, and buying items on credit,<sup>72</sup> has reduced (Figure 20). This does not necessarily reflect an increase in financial resources, rather it is likely that these strategies have become less viable due to cash shortages. Reduced access to cash may have prevented people from borrowing money or buying on credit, while the reduction in the quantity and diversity of assistance received likely impeded the sale of assistance items. KIs reported that while some households were still selling assistance items as a means to obtain cash, the practice had reduced, as households needed the assistance items themselves to meet increasing needs, prices had gone down and purchasing power was low. Across sectors, KIs frequently reported that people were unable to meet needs due to a lack of money. For instance, the proportion of households reporting having gone into debt to cover health expenses fell from 55% in 2019<sup>73</sup> to 14% in 2020.

*“Due to the lockdown, people who used to earn money are jobless or unemployed now. So, they can’t buy extra food. They are facing problems running their families.” – Female KI (Ukhiya)*

*“When we get ill, and have no money for treatment, then we have to sell some of the rations we receive. There are so many diseases and so many people are getting ill in the camp at the moment, we don’t have money for treatment, and we couldn’t see doctors. So we have difficulty getting treatment.” – Male KI (Ukhiya)*

*“They do nothing [to repair their shelter], just living in a miserable condition. Those who can afford it, they buy shelter materials and repair the shelter. [...] [The main reason for not repairing shelters is that] they can’t afford to buy shelter items.” – Female KI (Ukhiya)*

*“Caregivers who are capable and earning money, they appoint a home tutor to continue their children’s education, but some can’t afford this and their children do nothing.” – Female KI (Ukhiya)*

*“Yes, previously they can get a moderate price by selling [assistance] items, but since the lockdown, prices have gone down and they are not getting a good amount.” – Male KI (Teknaf)*

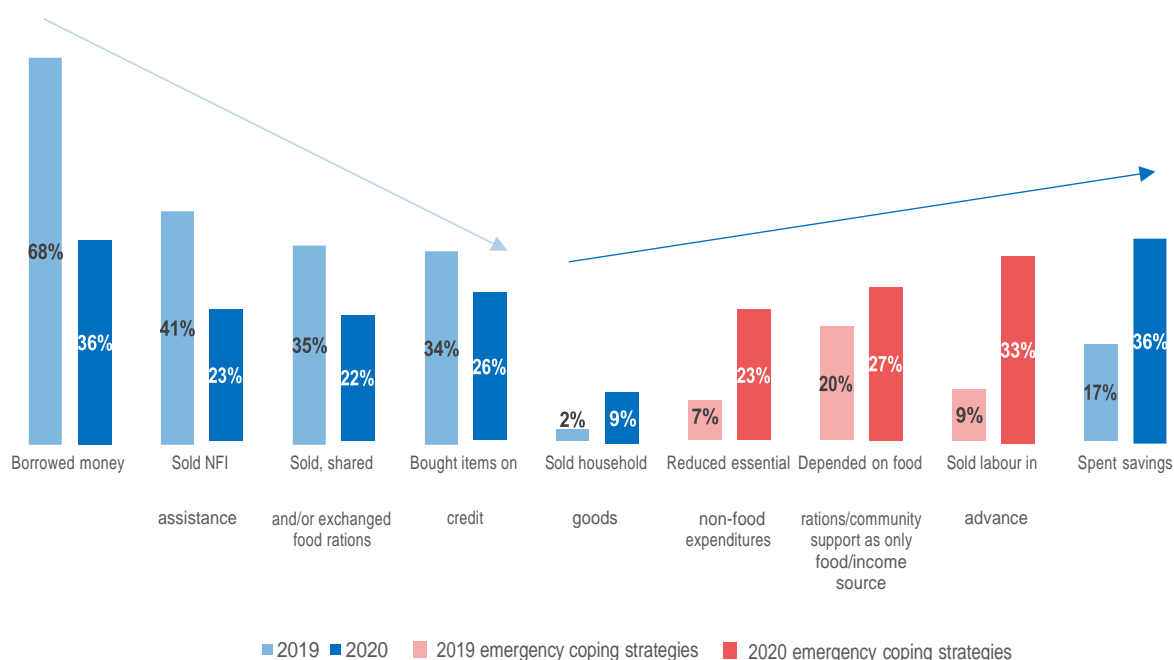
*“Before they used to sell their food items and now they don’t sell them, because they need them for their own house.” – Male KI (Ukhiya)*

As a result, households are increasingly adopting more extreme coping strategies, while simultaneously eroding their asset bases and savings (Figure 20). The adoption of emergency coping mechanisms may have long-term, potentially irreversible negative impacts on individual safety or well-being. As household assets reduce, households become more vulnerable to risks such as a decrease in overall health due to a decreased ability to adopt such coping strategies to seek treatment in the future, increasing food insecurity and malnutrition, and extreme protection risks, such as trafficking, child marriage, eviction, and forced or exploitative labour. Moreover, reduced savings and depleted assets may seriously limit households’ ability to cope with future shocks, as less extreme coping strategies become exhausted. This will render households increasingly vulnerable to the recurrent monsoon damage or other natural hazards, as well as any future lockdowns, and household-level shocks, such as sickness and disease.

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<sup>72</sup> ISCG, 2019.

<sup>73</sup> Ibid.



**Figure 20** % of households reporting having engaged in coping mechanisms due to a lack of money to meet basic needs in the 30 days prior to data collection

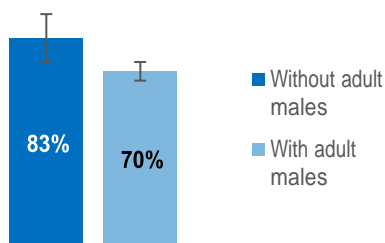
## Vulnerability

**Being less able to absorb shocks, households that were more vulnerable pre-COVID-19 are likely to also have been most vulnerable to the secondary impacts of the COVID-19 outbreak.** Households that have often been identified as most vulnerable in the past include female-headed households and households without a male of working age, households with persons with disability (PWDs), and large households (5+ members) (or households with a high dependency ratio (> 2)). Female-headed households or households without males of working age are often more vulnerable, as they have substantially less access to self-reliance activities, and face more barriers accessing any type of assistance due to limited social networks, lower levels of education and language skills, limited working opportunities, increased exposure to sexual and gender-based violence (SGBV), childcare duties, and sociocultural norms, which restrict their mobility. Households with PWDs typically spend more money on medical expenses and incur higher levels of debt to pay for those expenses. This leaves them less money to spend on food and other essential items, and increases their use of negative coping mechanisms to meet their needs. Lastly, large households or households with high dependency ratios tend to be more economically vulnerable. Previous studies, for instance, found those households to be more likely to borrow money, in particular to cover health-related costs. This is especially the case if household size is compounded by other vulnerabilities, e.g. for large female-headed households.<sup>74</sup> Those patterns of vulnerability were also reflected in the J-MSNA results.

### *Households without adult males*

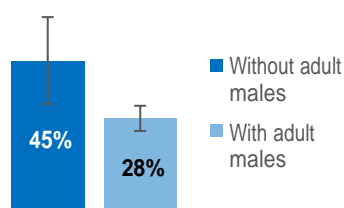
Households without adult males were significantly more likely to report having adopted food-based coping strategies in response to a lack of food than households with adult males (Figure 21)

<sup>74</sup> ACAPS, ACAPS Thematic Analysis – Bangladesh: Characteristics of vulnerable households in the Rohingya refugee response (Cox’s Bazar, 2020). Available [here](#) (accessed 13 November 2020).

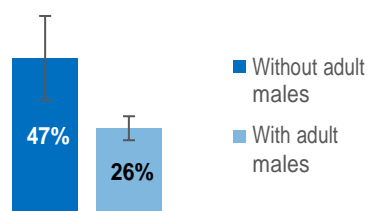


**Figure 21** % of households reporting adopting food-based coping mechanisms in the seven days prior to data collection due to a lack of food by presence of adults males in the household ( $p \leq 0.05$ )<sup>75</sup>

As outlined above, this is likely related to women having less access to self-reliance activities as well as other forms of assistance, increasing the challenges for households without adult males to meet their basic needs. As such, those households were significantly more likely to report not having been involved in any self-reliance activities or receiving any other form of cash assistance (Figure 22). Reduced service provision in camps following the enactment of COVID-19 containment measures also appears to have disproportionately affected households without adult males across other sectors as well, with those households being significantly more likely to report having lost access to basic services as a result of the COVID-19 outbreak than their counterparts with adult males (Figure 23).



**Figure 22** % of households reporting not having accessed any self-reliance activities and/or cash assistance in the 30 days prior to data collection by presence of adult males ( $p\text{-value} \leq 0.01$ )<sup>76</sup>



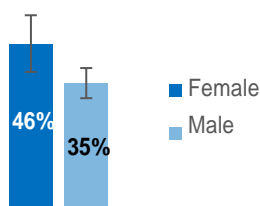
**Figure 23** % of households reporting lost or severely diminished access to basic services as an impact of the COVID-19 outbreak by presence of adult males ( $p\text{-value} \leq 0.001$ )<sup>76</sup>

Limited freedom of movement for women further compounds the challenges largely female households face meeting their needs. Households with female respondents were significantly more likely to report issues accessing markets (Figure 24) and were also significantly more likely to report a lack of transport as one specific barrier (Figure 25). The latter may be related to safety concerns women have walking long distances to markets. In addition, only 29% and 25% of households were of the opinion that women could go alone to work outside the house or to the market, respectively. While households with female respondents more frequently reported that women could go alone to work or to the market than households with male respondents (Figure 26), the majority of households with female respondents did not report that women could go to work or to markets alone. The generally higher proportion of households with female respondents that reported that women could go alone is likely linked to the fact that the majority of households with female respondents were female-headed households. In those households, women may see themselves more constrained to go to such places due to a lack of alternatives, but still in more than half the cases they do not consider themselves able to. Clearly, this poses severe challenges to meeting household needs for those households.

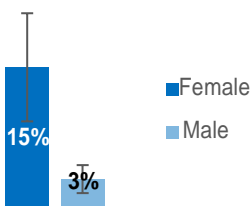
<sup>75</sup> Results for households without adult males are representative with a +/-11% margin of error ( $n = 82$ ).

<sup>76</sup> Ibid.

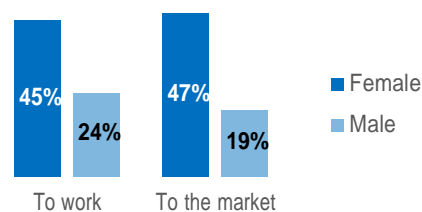




**Figure 24** % of households reporting any issues accessing markets in the four weeks prior to data collection by gender of respondent (p-value  $\leq 0.05$ )<sup>77</sup>

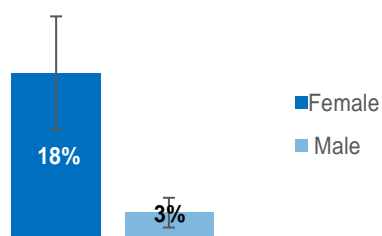


**Figure 25** % of households reporting a lack of transport to access markets in the four weeks prior to data collection by gender of respondent (p-value  $\leq 0.0001$ )<sup>77</sup>

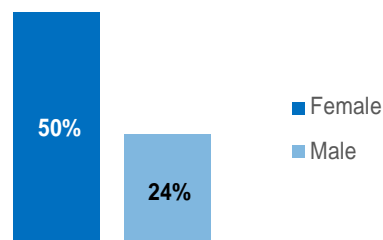


**Figure 26** % of households reporting that women can go alone to work/the market by gender of respondent<sup>77</sup>

The limited mobility of women may also exacerbate the protection risks they are exposed to, as it impedes their access to services outside their home, possibly preventing them from seeking assistance. Households with female respondents were significantly more likely to report that they would refer a friend who had experienced sexual assault to women-friendly spaces (WFS) (Figure 27), but only half the households with female respondents and 24% of households with male respondents thought women could go to WFS alone (Figure 28). Thus, even if they wanted to access WFS, women are likely to face challenges doing so.



**Figure 27** % of households reporting preferred point-of-contact if they needed to refer a friend who had been sexually assaulted by gender of respondent (p-value  $\leq 0.0001$ )<sup>78</sup>



**Figure 28** % of households reporting that women can go alone to WFS by gender of respondent<sup>78</sup>

Moreover, several KIs indicated particular challenges for women accessing assistance.

*“If a mother and her child do not go to the distribution centre to collect pusti or sujhi, they will not get nutrition support. [...] If anyone else goes instead of the mother, they will not be provided the nutrition support.”* – Male KI (Ukhiya)

*“Individual women could not do anything. If they go to the distribution centre, they also need assistance to carry their items.”* – Male KI (Ukhiya)

Lastly, gender appears to play a role in the interaction with humanitarian actors, with households without adult males more frequently reporting rarely or never having been consulted on needs, preferences, or the delivery of humanitarian assistance (Figure 29). This difference is significant with a p-value  $\leq 0.1$ . At the same time, households with female respondents were significantly more likely to report a lack of door-to-door information sharing as a reason for not having received enough information on the types of services available to households (Figure 30), and they more frequently reported not having had to provide feedback or make complaints (Figure 31). Similar to the case of households not

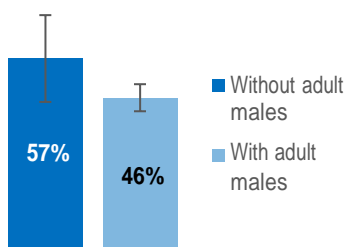
<sup>77</sup> Results for households with female respondents are representative with a +/-7% margin of error (n = 211).

<sup>78</sup> Ibid.

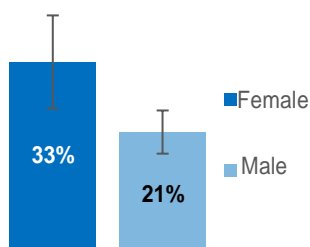
speaking English or Bangla, the latter is likely reflective of females being less likely to try and make use of any feedback mechanism rather than actually being less likely having to give feedback.

*“Yes, mostly females are facing challenges [providing feedback], because they are conservative and not used to going outside. [...] It is better to have female volunteers going door to door and collect the issues, if any females have.” – Male KI (Ukhiya)*

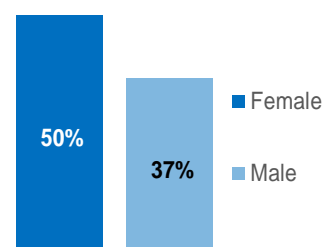
In sum, predominantly female households are not only less likely to be able to report problems but also less likely to have all the information they need to access assistance and to have their voices represented in the design of assistance programmes.



**Figure 29** % of households reporting never or rarely having been consulted on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak by presence of adult males<sup>79</sup>



**Figure 30** % of households not having received enough information on humanitarian assistance reporting no door-to-door information-sharing as the reason by gender of respondent (p-value  $\leq 0.01$ )<sup>80</sup>



**Figure 31** % of households reporting not having had to give feedback/make complaints since the COVID-19 outbreak by gender of respondent<sup>80</sup>

### Households with PWDs

With only 3% of households in the survey reporting at least one member with disability, results for this group are not representative.<sup>81</sup> Nevertheless, these households were found to be significantly more likely to report having taken on debt to cover for health expenses as well as having adopted food-based coping strategies (p-value  $\leq .05$  for both), thus confirming the tendency outlined above of those households having to spend more on health care and therefore having less resources to cover for other needs, such as food.

### Large households and households with high dependency ratios

While no association was found between household size and FCS, few KIs highlighted an increased vulnerability of large households to food shortages. Other KIs reported that large households were more vulnerable to LPG shortages, the latter also being reflected in the fact that smaller households were significantly more likely to report having relied exclusively on LPG as a source of cooking fuel in the four weeks prior to data collection (Figure 32). In addition, as outlined above, households with high dependency ratios were found to be associated with higher levels of vulnerability of children related to the primary and secondary impacts of TLC closures (see Figure 17).

<sup>79</sup> Results for households without adult males are representative with a +/-11% margin of error (n = 82).

<sup>80</sup> This question was only asked to households reporting not having received enough information on any type of humanitarian assistance. Results for households with female respondents are representative with a +/-8% margin of error (n = 186).

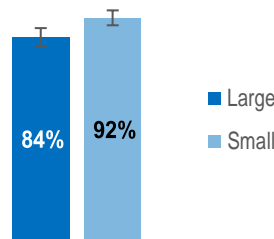
<sup>81</sup> In total, 31 households reported a PWD.

*“Those households with more than five people are mainly affected [by food shortages]. The size of the family really matters for feeding them. Extended families need enough food for eating.” – Male KI (Ukhiya)*

*“Those families with more adult people are more affected [by food shortages] than families who have mostly children, because all are getting the same amount of rice.” – Male KI (Ukhiya)*

*“Before the lockdown, the LPG refill cycle was 30 days, but now it changed to 46 or 47 days. Households with more than four members are facing a shortage of gas, as their gas stock finishes 12 or 13 days before the refill.” – Female KI (Ukhiya)*

*“Yes, most big families face problems, as their gas stock finishes five to eight days before the refill.” – Male KI (Teknaf)*



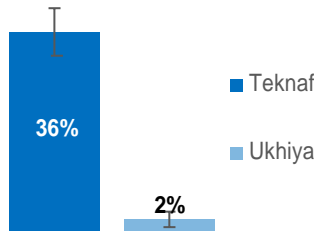
**Figure 32** % of households reporting relying exclusively on LPG as a source of cooking fuel in the four weeks prior to data collection by household size (p-value  $\leq 0.01$ )<sup>82</sup>

### Differences between upazilas

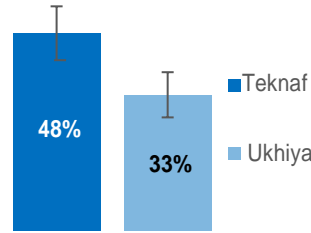
In addition to differences between households, there seem to be differences in access to services or service provision between camps located in the two different upazilas, with camps in Teknaf seemingly being characterised by lower levels of service provision, utilisation or outreach across multiple sectors. Already the 2019 J-MSNA showed that households in certain camps in Teknaf are much more likely having to make rent payments,<sup>83</sup> a trend that remained unchanged with households in Teknaf continuing to be significantly more likely to report so (Figure 33). Additionally, households in Teknaf were significantly more likely to report not having spoken to a teacher about their children’s education since TLCs had closed (Figure 34) and having children aged 6 to 59 months not enrolled in a nutrition-feeding programme (Figure 35), also indicating greater gaps in camps in Teknaf for those indicators.

<sup>82</sup> Results for small households are representative with a +/-6% margin of error (n = 360).

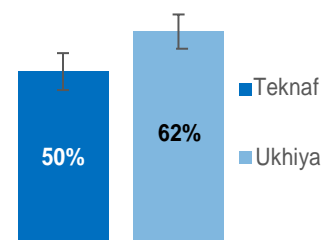
<sup>83</sup> ISCG, 2019.



**Figure 33** % of households reporting having had to pay rent (cash) to live in their current shelter in the six months prior to data collection by upazila (p-value  $\leq 0.0001$ )

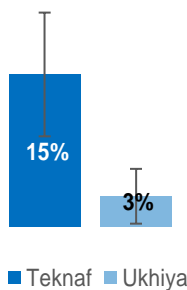


**Figure 34** % of households with children that attended formal learning before the COVID-19 outbreak reporting not having spoken to a teacher since TLCs closed by upazila (p-value  $\leq 0.05$ )<sup>84</sup>

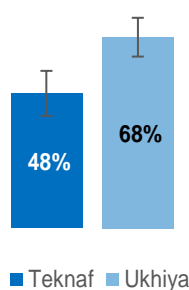


**Figure 35** % of children 6-59 months reported to be enrolled in a nutrition-feeding program by upazila (p-value  $\leq 0.001$ )<sup>85</sup>

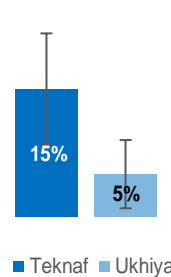
Lastly, households in Teknaf were significantly more likely to report accessing government clinics to seek health treatment (Figure 36) and significantly less likely to report accessing NGO clinics (Figure 37). Likely linked to the more limited utilisation of (free) NGO services is also a significantly higher proportion of households in Teknaf reporting having done home treatment due to a lack of money to go to hospital (Figure 38). Larger gaps in health outcomes in camps in Teknaf might therefore be expected. Limited access to health services is further indicated by the significantly lower proportion of households in Teknaf reporting having received facemasks from humanitarian actors compared to Ukhiya (Figure 39).



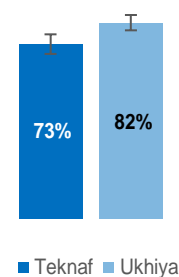
**Figure 36** % individuals reported to have sought treatment at a government clinic by upazila (p-value  $\leq 0.001$ )<sup>86</sup>



**Figure 37** % individuals reported to have sought treatment at an NGO clinic by upazila (p-value  $\leq 0.001$ )<sup>86</sup>



**Figure 38** % of households reporting having done home treatment due to a lack of money by upazila (p-value  $\leq 0.01$ )<sup>87</sup>



**Figure 39** % of households reporting having received facemasks from humanitarian actors by upazila (p-value  $\leq 0.01$ )<sup>87</sup>

## Accountability to Affected Populations

Types of assistance on which households most frequently reported not having received enough information include livelihoods, NFIs, shelter, remote education and nutrition, reflecting both priority needs and areas of greatest concern. The findings also suggest possible uncertainty over access to specific types of assistance during the lockdown and how these services will be provided in the future. Livelihoods, shelter/NFIs, education and nutrition assistance were all

<sup>84</sup> This question was only asked to households with children who regularly attended TLCs prior to the COVID-19 outbreak. Results are representative with a +/-7% margin of error for Teknaf (n = 248) and a +/-6% margin of error for Ukhiya (n = 282).

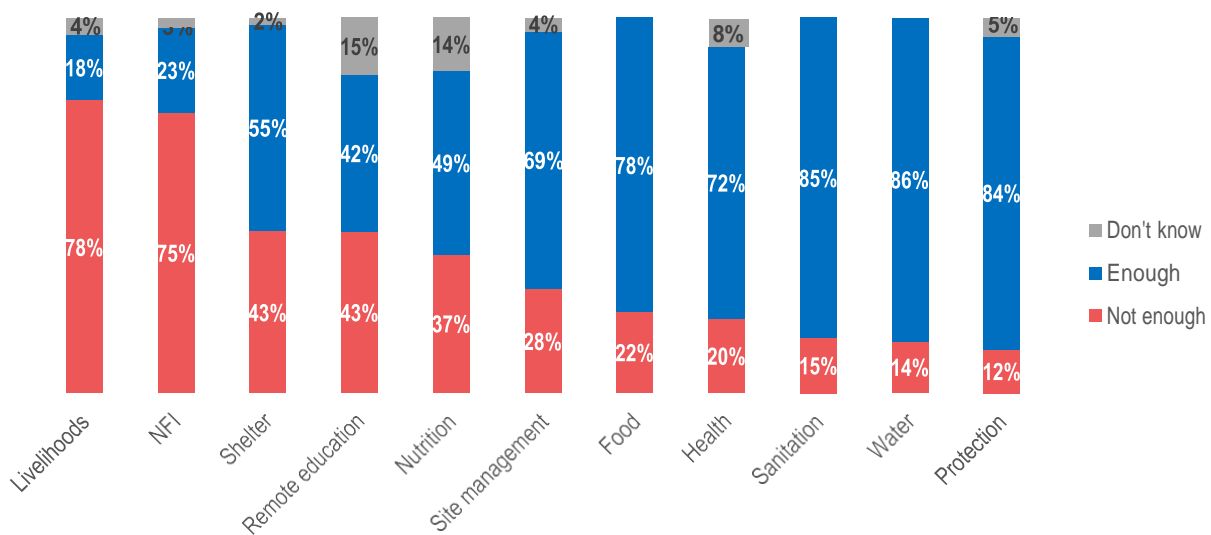
<sup>85</sup> Results are representative with a +/-6% margin of error for Teknaf (n = 338) and Ukhiya (n = 370).

<sup>86</sup> This question was asked about all individuals for whom treatment was sought. Results are representative with a +/-6% margin of error for Teknaf (n = 177) and Ukhiya (n = 178).

<sup>87</sup> This question was only asked to households that required health treatment or reported a household member who had died in the 30 days prior to data collection. Results are representative with a +/-10% margin of error for Teknaf (n = 113) and Ukhiya (n = 109).

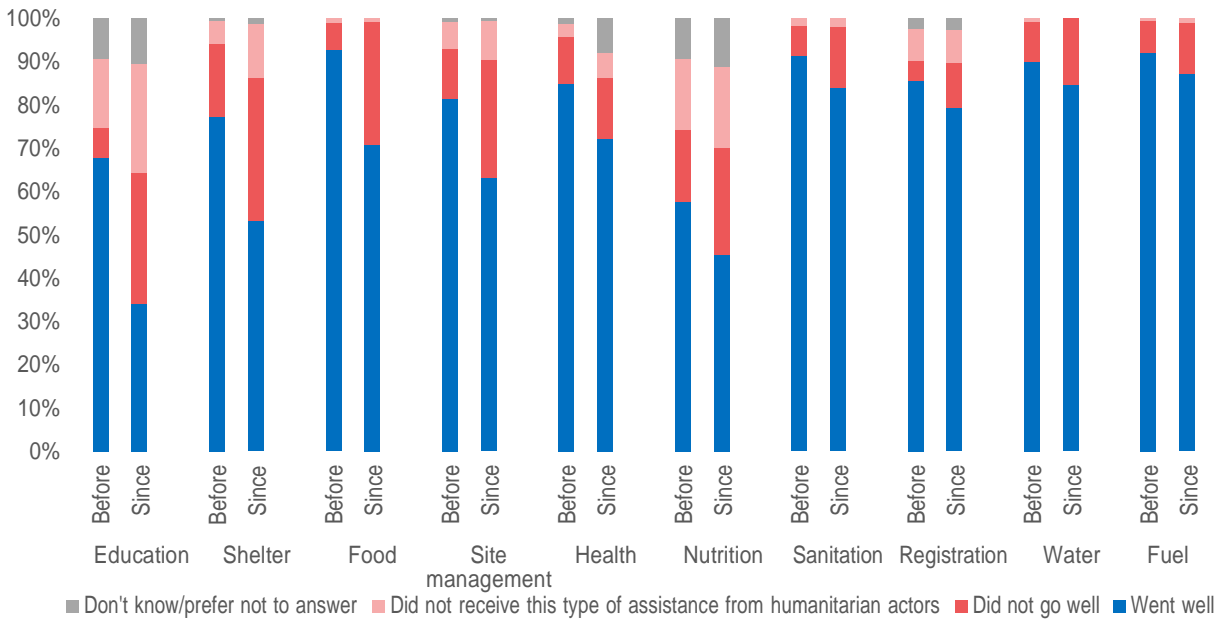
scaled down during the lockdown and it is these types of assistance that households particularly feel they have not received enough information on since the COVID-19 outbreak. Correspondingly, there seem to be less gaps for sectors, such as Food Security, Health and WASH, with greater continuity in the provision of assistance also during the lockdown (Figure 40).

The most common reason reported by households for a lack of information was that not enough information on services was available, as reported by 37% of households, followed by households not having sought information and aid workers not having shared information, both reported by 26% of households. This seems to indicate the perception that the barrier is a genuine lack of information rather than an inability of households to access information. As indicated above, a lack of door-to-door information-sharing was reported as a barrier particularly by households with female respondents (Figure 30). KIs commonly suggested to best distribute information in Rohingya via community leaders, humanitarian actors and Rohingya-speaking volunteers, imams/mosques, or microphones.



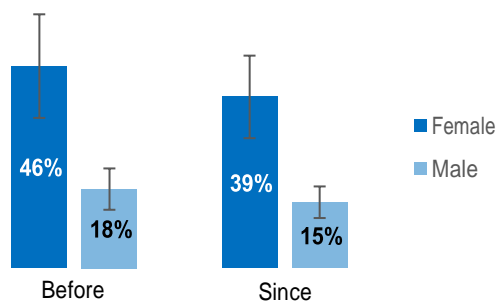
**Figure 40** % of households reporting having received enough information about humanitarian services/types of assistance since the COVID-19 outbreak

Comparing household levels of satisfaction with assistance before and after the COVID-19 outbreak shows the greatest absolute decreases in the proportion of households reporting assistance having gone well related to education, shelter, food, site management, health and nutrition assistance. The proportion of households reporting those types of assistance having gone well decreased by 12 (nutrition) to 34 (education) percentage points since the initiation of COVID-19 containment measures. Similarly, the proportion of households reporting those types of assistance not to have gone well increased by 8 (nutrition) to 24 (education) percentage points (Figure 41). The most common reasons for not having been satisfied with assistance both before and since the COVID-19 outbreak included assistance not having been enough (reported by 64% of households not having been satisfied as a reason for not having been satisfied before the COVID-19 outbreak, and by 68% of households as a reason for not having been satisfied since the COVID-19 outbreak), not having been useful (24% and 20%), not having been frequent enough (22% and 19%) and poor quality services (9% and 10%).



**Figure 41** % of households reporting satisfaction with assistance before the COVID-19 outbreak (and since the beginning of the year), and since the COVID-19 outbreak<sup>88</sup>

While not included in Figure 40, households with female respondents were disproportionately not satisfied with psychosocial support – 26% and 25%, respectively, of households with female respondents reported psychosocial support not to have gone well before and since the COVID-19 outbreak, compared to 7% and 10%, respectively, of households with male respondents. Moreover, households with female respondents were significantly more likely to report assistance not having been useful as a reason for not having been satisfied both pre- and post-COVID-19 (Figure 42). At least in part a reason for this could be the lower proportion of households without adult males reporting not having been consulted on humanitarian assistance (see Figure 29), with those households therefore being less likely to see their preferences considered in the design of humanitarian assistance programmes.



**Figure 42** % of households not having been satisfied with assistance reporting assistance not having been useful by gender of respondent (p-value for both  $\leq 0.0001$ )<sup>89</sup>

<sup>88</sup> Out of all services that were assessed, the graph displays the ten services with the highest absolute decrease in the proportion of households reporting assistance having gone well before and after the COVID-19 outbreak

<sup>89</sup> This question was only asked to households not having been satisfied with any type of assistance. Results for female respondents are representative with a +/- 10% margin of error pre-COVID-19 (n = 98) and with a +/- 8% margin of error post-COVID-19 (n = 149).



## CONCLUSION

Almost 900,000 Rohingya refugees continue to reside in camps in Cox's Bazar District, Bangladesh. The crisis has now entered its fourth year, but a return of the refugees to Myanmar in the near or medium term continues to be unlikely. As such, there is a continued need for up-to-date information on the needs and vulnerabilities of all affected populations. At the same time, COVID-19 containment measures and related restricted service provision in camps since March 2020 are likely to have impacted pre-existing needs and service gaps. Against this background, this J-MSNA was conducted to support detailed humanitarian planning and enhance the ability of operational partners to meet the strategic aims of donors and coordinating bodies. More specifically, the J-MSNA aimed to assess current levels of need and service gaps among refugee populations, in particular within the context of the COVID-19 pandemic and including a basic understanding of inter-household differences in outcomes. The assessment covered Rohingya refugee populations residing in all 34 camps in Teknaf and Ukhiya Upazilas, and was implemented through the ISCG's MSNA TWG.

Findings show that needs most prioritised by households included shelter materials, access to food, and access to IGAs. Particularly households with female respondents further prioritised access to safe and functional latrines, as well as electricity. Within the constraints of the COVID-19 containment measures, the provision of few services remained extensive. However, many service gaps that had already existed pre-COVID-19 also remained. The majority of households (69%) reported facing issues with their shelter. While the occurrence of shelter issues as such was not directly impacted by the COVID-19 outbreak, limited and delayed assistance meant that they had become harder to cope with. Both shelters and the wider camp environment also continue to be characterised by a lack of light, reported by 58% of households. This increases protection risks, in particular for women and girls, and prevents households from conducting basic activities after dark, such as studying. Further, 40% of children aged 6 to 59 months were reportedly not enrolled in nutrition-feeding programmes, with a lack of effective communication and awareness of such programmes and their benefits possibly being one explanatory factor.

Education enrolment remained low. At the same time, the loss of access to education services as a result of the COVID-19 outbreak constituted a major concern to households and KIs. The majority of households (62%) reported having faced challenges in supporting their children's remote study, with children from households with high dependency ratios as well as less educated households reportedly having been significantly more likely not to have studied at home. Disrupted daily routines and access to TLCs also led to concerns about children's well-being among KIs, while households reported increases in child protection issues in their communities, most notably in child labour and children going missing, both having been reported to have increased in communities by 16% of households. Impacts of exacerbated protection risks in camps may have been compounded by the limited presence of protection actors following the enactment of COVID-19 containment measures. Moreover, likely as a result of the reduced diversity in food assistance and the disruption of different types of self-reliance activities and cash assistance, FCS worsened considerably, indicating heightened levels of food insecurity. Increased challenges in updating documentation likely aggravated access to food assistance for households having moved camps during the lockdown, potentially with severe consequences. The overall high proportion of households reporting having adopted food-based coping strategies in the seven days prior to data collection due to a lack of food (71%) is further indicative of food shortages and consumption gaps. In addition, overall health outcomes may have been negatively affected by the impact of the COVID-19 outbreak on health-seeking behaviour. The proportion of individuals reported sick enough to require medical

treatment dropped from 35% in 2019 to 9% in 2020, likely reflecting a drop in the proportion of individuals that sought treatment when they should have, and thus a reduction in health-seeking behaviour.

Exacerbated needs, coupled with reduced access to self-reliance activities, cash and other forms of assistance led to an erosion of coping capacities. As households were not able anymore to rely on previously common coping strategies, such as borrowing money, selling assistance and buying items on credit, they increasingly adopted more crisis-level coping strategies, while simultaneously eroding asset bases and savings. Such an erosion of coping capacities will likely render households more vulnerable to future shocks as well as a possibly continued disruption of assistance and lack of access to livelihood opportunities. It can further be expected to have negative repercussions on access to health care, food security and nutrition as well as household exposure to extreme protection risks.

Households that were more vulnerable pre-COVID-19 are likely to also have been most vulnerable to the secondary impacts of the COVID-19 outbreak. These households include female-headed households or households without a working-age or adult male, households with PWDs, and large households or households with high dependency ratios. Both households without adult males and households with PWDs were significantly more likely to report having adopted food-based coping strategies in the seven days prior to data collection due to a lack of food. Moreover, households without adult males were significantly more likely to report having lost access to basic services following the COVID-19 outbreak. Results further indicate females and female-headed households to interact less with humanitarian actors, possibly contributing to a higher proportion of households with female respondents (39%) reporting assistance not having been useful as a reason for not having been satisfied with assistance since the COVID-19 outbreak compared to households with male respondents (15%).

The proportion of households reporting different types of assistance having gone well before and since the COVID-19 outbreak decreased most for assistance related to education, shelter, food, site management, health care and nutrition. At the same time, the greatest information needs exist around livelihoods, shelter/NFIs, education and nutrition assistance. As all those types of assistance had been scaled down following the COVID-19 outbreak, the latter possibly reflects uncertainty about households' continued access to those services now and in the future as well as households' desire to receive clear information on this.

Given the exacerbated needs and the severe erosion of coping capacities, as well as the quickly changing levels of need that can be expected as the pandemic evolves and humanitarian programming continues to be adapted, in the near and medium term, it will be of great importance to continue to closely monitor needs and service gaps to allow for continued evidence-based programming. The results of the J-MSNA are characteristic of the very specific circumstances that prevailed at the time of data collection. As the situation changes, especially the most concerning trends uncovered by the findings, including in relation to food security, health-seeking behaviour and likely accompanying adverse impacts on health, education, and child as well as general protection risks should be closely monitored.

Given the scope and practical limitations of this assessment, information gaps persist. First, additional information on the impact of the lockdown on levels of security, protection-related incidents and their impacts on household and individual well-being may support effectively countering negative trends. Secondly, a better understanding of the impacts of the COVID-19 outbreak and associated containment measures on the most vulnerable households may help more effectively alleviate those. Both will require restored access to camps and carefully designed in-person data collection. In the long term and in the context of future MSNAs, a more comprehensive assessment of key barriers to

accessing different types of services faced by different groups of households and individuals may contribute to reducing persisting vulnerabilities in the long run.

## ANNEXES

## Annex 1: Household surveys completed per camp

Table 1 List of surveys completed per camp against camp population and targeted minimum number of surveys

| Upazila           | Camp             | Total number of households | Targeted minimum number of surveys | Completed number of surveys |
|-------------------|------------------|----------------------------|------------------------------------|-----------------------------|
| Ukhiya            | Camp 1E          | 8,480                      | 21                                 | 24                          |
|                   | Camp 1W          | 8,376                      | 21                                 | 22                          |
|                   | Camp 2E          | 6,083                      | 15                                 | 22                          |
|                   | Camp 2W          | 5,444                      | 14                                 | 17                          |
|                   | Camp 3           | 8,056                      | 20                                 | 24                          |
|                   | Camp 4           | 7,018                      | 18                                 | 21                          |
|                   | Camp 4 Extension | 1,635                      | 4                                  | 7                           |
|                   | Camp 5           | 5,483                      | 14                                 | 18                          |
|                   | Camp 6           | 4,834                      | 12                                 | 13                          |
|                   | Camp 7           | 8,166                      | 20                                 | 22                          |
|                   | Camp 8E          | 6,186                      | 15                                 | 16                          |
|                   | Camp 8W          | 6,609                      | 17                                 | 21                          |
|                   | Camp 9           | 7,181                      | 18                                 | 20                          |
|                   | Camp 10          | 6,342                      | 16                                 | 18                          |
|                   | Camp 11          | 6,146                      | 15                                 | 18                          |
|                   | Camp 12          | 5,305                      | 13                                 | 14                          |
|                   | Camp 13          | 8,801                      | 22                                 | 24                          |
|                   | Camp 14          | 6,574                      | 16                                 | 17                          |
|                   | Camp 15          | 10,461                     | 26                                 | 30                          |
|                   | Camp 16          | 4,497                      | 11                                 | 11                          |
| Camp 17           | 3,783            | 9                          | 10                                 |                             |
| Camp 18           | 6,076            | 15                         | 17                                 |                             |
| Camp 19           | 4,868            | 12                         | 13                                 |                             |
| Camp 20           | 1,572            | 4                          | 6                                  |                             |
| Camp 20 Extension | 1,834            | 5                          | 6                                  |                             |
| Kutupalong RC     | 3,143            | 8                          | 14                                 |                             |
| Teknaf            | Camp 21          | 3,839                      | 42                                 | 41                          |
|                   | Camp 22          | 4,279                      | 47                                 | 48                          |
|                   | Camp 23          | 2,381                      | 26                                 | 33                          |
|                   | Camp 24          | 5,776                      | 64                                 | 65                          |
|                   | Camp 25          | 1,545                      | 17                                 | 17                          |
|                   | Camp 26          | 9,034                      | 100                                | 99                          |
|                   | Camp 27          | 3,245                      | 36                                 | 42                          |
|                   | Nayapara RC      | 4,371                      | 48                                 | 46                          |
| <b>Total</b>      | <b>187,423</b>   | <b>761</b>                 | <b>836</b>                         |                             |

## Annex 2: Key informant interviews completed by gender and camp

Table 2 List of key informants completed per camp, overall and by gender of respondent

| Upazila           | Camp             | Female    | Male      | Total     |
|-------------------|------------------|-----------|-----------|-----------|
| Ukhiya            | Camp 1E          | 1         | 1         | 2         |
|                   | Camp 1W          | -         | -         | -         |
|                   | Camp 2E          | -         | 2         | 2         |
|                   | Camp 2W          | 1         | -         | 1         |
|                   | Camp 3           | -         | 1         | 1         |
|                   | Camp 4           | 2         | 2         | 4         |
|                   | Camp 4 Extension | -         | -         | -         |
|                   | Camp 5           | -         | 1         | 1         |
|                   | Camp 6           | -         | 2         | 2         |
|                   | Camp 7           | -         | 1         | 1         |
|                   | Camp 8E          | -         | -         | -         |
|                   | Camp 8W          | -         | 1         | 1         |
|                   | Camp 9           | 1         | -         | 1         |
|                   | Camp 10          | -         | 1         | 1         |
|                   | Camp 11          | -         | 1         | 1         |
|                   | Camp 12          | -         | 1         | 1         |
|                   | Camp 13          | -         | -         | -         |
|                   | Camp 14          | -         | -         | -         |
|                   | Camp 15          | 1         | -         | 1         |
|                   | Camp 16          | -         | -         | -         |
| Camp 17           | 1                | 4         | 5         |           |
| Camp 18           | 1                | -         | 1         |           |
| Camp 19           | -                | 1         | 1         |           |
| Camp 20           | -                | 1         | 1         |           |
| Camp 20 Extension | 1                | -         | 1         |           |
| Kutupalong RC     | -                | 1         | 1         |           |
| Teknaf            | Camp 21          | -         | 1         | 1         |
|                   | Camp 22          | -         | 1         | 1         |
|                   | Camp 23          | 1         | -         | 1         |
|                   | Camp 24          | -         | 1         | 1         |
|                   | Camp 25          | -         | 1         | 1         |
|                   | Camp 26          | 1         | 1         | 2         |
|                   | Camp 27          | -         | 1         | 1         |
|                   | Nayapara RC      | 1         | 1         | 2         |
| <b>Total</b>      |                  | <b>12</b> | <b>28</b> | <b>40</b> |

## Annex 3: Agenda of enumerator training

Figure 43 Agenda of enumerator training (for both refugee and host community survey)

| <b>AGENDA</b>   |   |   |             |
|---|---|---|-------------|
| <b>Multi-Sector Needs Assessment Training, July 2020</b>  |   |   |             |
| <b>(jointly facilitated by UNHCR/REACH)</b>   |   |   |             |
| <b>Purpose/Overall aim –</b>  |   |   |             |
| To enable, strengthen and improve the skills and capacity of enumerators to be able to conduct data collection for multi-sector needs assessment to a high quality and ethical standard.  |   |   |             |
| <b>Learning outcomes –</b>  |   |   |             |
| <ul style="list-style-type: none"> <li>- Understanding of the, objectives and purpose of the multi-sector needs assessment</li> <li>- Knowledge and understanding of research ethics (confidentiality, informed consent, do no harm)</li> <li>- In-depth understanding of questionnaires</li> </ul>               |   |   |             |
| <b>Timing –</b>   |   |   |             |
| <ul style="list-style-type: none"> <li>- Please note that the timing will be: <b>8:30 am start</b> and <b>5:30 pm finish</b>.</li> <li>- Two 15 minute breaks and one (1 hour) lunch break will be given across the day.</li> <li>- Agenda time is a guide only. <b>Training venue-</b> Hangouts/Skype</li> </ul> |   |   |             |
| Date & Time   | Session   | Objectives  | Facilitator |
| <b>Training Day 1, 16 July 2020 (Thursday)</b>  |   |   |             |
| 08:30-9:30 am   | Registration Hangouts/Skype connection trial                                | Ensure flexibility of doing online training session   | REACH       |
| 9:30-10:45 am   | Team Formation (Icebreaker/Activity)  | Develop a team bonding  | REACH       |
| 10:45-11:00 am  | Tea break   |   |             |
| 11:00-11:30 pm  | Introduction to KoBo Collect  | Articulate key facts of Kobo using  | UNHCR       |
| 11:30-12:15 pm  | Explanation- Role of FC, FA, TL, Enumerator                                 | Understanding roles   | REACH       |
| 12:15-1:00 pm   | Data collection instructions  | Understanding allocation of phone numbers, call-back procedures, etc.                       | REACH       |
| 1:00 -2:00 pm   | Lunch break   |   |             |
| 2:00 – 3:45 pm  | Language training   | Improves Chittagonian/Rohingya speaking and reading   | REACH       |
| 3:45 - 4:00 pm  | Tea break   |   |             |
| 4:00 – 5:30 pm  | Continuation of language training (if needed)                               | Improves Chittagonian/Rohingya speaking and reading   | REACH       |
| <i>End of Day 1</i>   |   |   |             |
| <b>Training Day 2, 19 July 2020 (Sunday)</b>  |   |   |             |
| 8:30-9:00 am  | Registration  |   |             |
| 9:00-9:15 am  | Welcome & Introduction, Learning objectives, Learning Agreement for the day | Understand purpose, objectives and agenda of the training<br>Establish a learning agreement | REACH       |
| 9:15-9:45 am  | Overview of research objectives and scope                                   | Familiarize research teams with research objectives   | REACH       |
| 9:45-10:45 am   | Research ethics and code of conduct   | Summarise the outline of core research principles (including AAP, PSEA, referrals)          | UNHCR       |
| 10:30-10:45 am  | Refresher on methodology  | Understanding basic research principles, random sampling                                    | REACH       |
| 10:45-11:00 am  | Tea break   |   |             |



|  |  |  |               |
|--|--|--|---------------|
| 11:00-11:30 am                               | Introduction to Phone Interview (guidance, challenges), Do's and don'ts of good interviewing                       | Identify challenges in surveying over phone call and positive communication that supports a safe and comfortable interview | UNHCR         |
| <b>SPLIT INTO TWO DIFFERENT GROUPS</b>       |  |  |               |
| 11:30-12:30 pm                               | Introduction to questionnaire (Hard copy)  | Opening part of the questionnaire (informed consent, basic information of HH)  | REACH         |
| 12:30 – 1:00 pm                              | Shelter/NFI (refugee) / Health (HC)  | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 1:00-2:00 pm                                 | Lunch break  |  |               |
| 2:00-2:30 pm                                 | Education (R) / Nutrition (HC)   | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 2:30 – 3:00 pm                               | Health (R) / Food security/Livelihoods (HC)  | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 3:00 – 3:30 pm                               | Nutrition (R) / WASH (HC)  | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 3:30 – 3:45 pm                               | Open questions   | Clarification of any open questions  | REACH         |
| 3:45-4:00 pm                                 | Tea break  |  |               |
| 4:00-4:30 pm                                 | Food security/Livelihoods (R) / Protection (HC)  | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 4:30 – 5:00 pm                               | WASH (R) / Gender (HC)   | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 5:00-5:30                                    | Open platform for questions  | Clarification of any open questions  | REACH         |
| <i>End of day 2</i>                          |  |  |               |
| <b>Training Day 3, 20 July 2020 (Monday)</b> |  |  |               |
| 8:30-9:00 am                                 | Registration   |  |               |
| 9:00-9:15 am                                 | Learning objectives, Learning Agreement for the day  | Develop clear participant expectations<br>Establish a learning agreement   | REACH         |
| 9:15-9:45 am                                 | Gender (R) / CWC/AAP (HC)  | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 9:45 – 10:15 am                              | Protection (R) / Education (HC)  | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 10:15 – 10:45 am                             | CWC/AAP (R) / Shelter/NFI (HC)   | Question-by-question review of questionnaire, clarification of any issues  | REACH/sectors |
| 10:45-11:00 pm                               | Tea break  |  |               |
| 11:00-1:00 pm                                | Questionnaire review using Kobo tool   | KOBO form review   | REACH         |
| 1:00-2:00 pm                                 | Lunch break  |  |               |
| 2:00-3:00 pm                                 | Questionnaire review using Kobo tool   | KOBO form review   | REACH         |
| 3:00-3:45 pm                                 | Mock interview session (small group calls between enumerators with team leader feedback within their small groups) | Exercise questionnaire with Kobo form  | REACH         |
| 3:00-3:45 pm                                 | Tea break  |  |               |
| 4:00-5:00 pm                                 | Continuation of mock session   | Exercise questionnaire with Kobo form  | REACH         |
| 5:00-5:30 pm                                 | Open platform for questions  | Clarification of any open questions  | REACH         |
| <i>End of day 3</i>                          |  |  |               |

| Training Day 4, 21 July 2020 (Tuesday) |                                      |  |             |
|--|--------------------------------------|--|-------------|
| 8:30-9:00 am                           | Registration                         |  |             |
| 9:00-9:30 am                           | Comprehension testing of key phrases | Test ability to recognize perplexing words           | REACH       |
| 9:30-10:45 am                          | Continuation of mock session         | Exercise questionnaire with Kobo form                | REACH       |
| 10:45-11:00 am                         | Tea break                            |  |             |
| 11:30-12:00 pm                         | Review with the whole group          | Clarification of open questions                      | REACH       |
| 12:00 – 1:00 pm                        | Continuation of mock session         | Exercise questionnaire with Kobo form                | REACH       |
| 1:00-2:00 pm                           | Lunch break                          |  |             |
| 2:00-2:30 pm                           | Feedback from test                   | Ensure understanding of key phrases                  | REACH       |
| 2:30-3:45 pm                           | Continuation of mock session         | Exercise questionnaire with Kobo form                | REACH       |
| 3:45-4:00 pm                           | Tea break                            |  |             |
| 4:00-4:30 pm                           | Review Day 1, Day 2                  | Refreshed memory on day 1 and day 2                  | REACH/UNHCR |
| 4:30-4:45 pm                           | Logistics for pilot days             | Check availability of mobile, enough mobile recharge | REACH       |
| 4:45-5:30 pm                           | Open platform for questions          | Clarification of any open questions                  | REACH       |
| <i>End of day 4</i>                    |                                      |  |             |
| Day 5, 22 July 2020                    | Pilot data collection                |  | REACH       |
| Day 6, 23 July 2020                    | Pilot review                         | Review of pilot, clarification of any open questions | REACH       |

**Note:** The first half of the Day 1 training will be for all enumerators, while the language training will only be for those conducting interviews in camps. Similarly, the first half of the Day 2 training day will be held with all enumerators together, and from the second half of the first day they will be split into two separate trainings for refugee and host community data collection.





## Annex 5: Partners involved in the assessment

Table 3 List of partners involved in each stage of the assessment

| Stage of the assessment                      | Partners involved  |
|--|--|
| Research design                              | MSNA TWG, led by the ISCG and comprised of UNHCR, IOM NPM, ACAPS and REACH |
| Tool design                                  | Sector partners, MSNA TWG  |
| Enumerator training                          | Sector partners, UNHCR, REACH  |
| Data collection                              | UNHCR, REACH   |
| Data cleaning, transcription and translation | REACH, TWB   |
| Data analysis                                | MSNA TWG, sector partners  |
| Secondary data review                        | ACAPS  |
| Dissemination                                | MSNA TWG   |



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