ISCG
INTER SECTOR COORDINATION GROUP

Rohingya Refugee Response
Bangladesh

INTER-SECTOR NEEDS ASSESSMENT

FEBRUARY 2025

BANGLADESH

ACKNOWLEDGEMENTS

The Inter-Sector Coordination Group (ISCG) would like to thank the Partners and Agencies for their contribution and support to the inter-sector needs assessment 2024.

OVERALL LEAD AND COORDINATION

ISCG INTER SECTOR COORDINATION GROUP | Rohingya Refugee Response Bangladesh

FINANCIAL SUPPORT FOR ISNA

IOM UN MIGRATION

UNHCR The UN Refugee Agency

TECHNICAL INPUTS AND GUIDANCE

Cox's Bazar Education Sector

COX'S BAZAR FOOD SECURITY SECTOR

HEALTH SECTOR COX'S BAZAR

LIVELIHOODS SKILLS DEVELOPMENT SECTOR

Cox's Bazar, Bangladesh NUTRITION SECTOR

PROTECTION SECTOR COX'S BAZAR, BANGLADESH

Child Protection

GBV Sub-Sector

SHELTER & CCCM SECTOR

WASH Sector Cox's Bazar

Accountability to Affected People (AAP)

Age and Disability

Emergency Preparedness and Response (EPR)

Energy and Environment Network (EEN)

Gender in Humanitarian Action (GiHA)

Information Management and Assessment Working Group (IMAWG)

Protection from Sexual Exploitation and Abuse (PSEA)

Youth Working Group (YWG)

TECHNICAL SUPPORT AND DATA COLLECTION

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This report presents the summary of the findings and analysis of the inter-sector needs assessment in Rohingya Refugee Camps, Bangladesh. Further details may be provided by the Sectors involved in the response.

Cover photo: Camp Aerial Overview©NPM UAV Picture, February 2024.

The findings of ISNA 2024 are considered current at the time the assessment was completed. As the situation evolves, including responses and field-level interventions, differences may arise between the report findings and subsequent developments and related data.

The publication was developed and produced by ISCG with technical contributions from Sectors, Cross Cutting Themes and Working Groups. The findings were validated in several fora led by the respective Sectors, Working Groups and ISCG. The ISCG hopes the findings herein provide useful and relevant information to guide the Rohingya Refugee Response going forward.

Click here to access to the ISNA Results Dashboard.

https://rohingyaresponse.org

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LIST OF ABBREVIATIONS

AAP	Accountability to Affected People
TWG	Technical Working Group
AM	Acute Malnutrition
ANC	Antenatal Care
APBn	Armed Police Battalion
AWD	Acute Watery Diarrhea
BDT	Bangladeshi Taka
BMD	Bangladesh Meteorological Department
CBLF	community-based learning facilities
CiC	Camp in Charge
CPIMS	Child Protection Information Management System
CPP	Cyclone Preparedness Programme
CPSM	Child Protection Situation Monitoring
CPSS	Child Protection Sub-Sector
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
DRRO	District Relief & Rehabilitation Office
EEN	Energy and Environment Network
EPR	Emergency Preparedness and Response
FDMN	Forcibly Displaced Myanmar Nationals
FFV	Fresh Food E-voucher
FSCD	Bangladesh Fire Service & Civil Defence
GBV	Gender-Based Violence
GBVIMS	Gender-Based Violence Information Management System
GiHA	Gender in Humanitarian Action
HC	Host Community
HH	Household
HLP	Housing and Land Property
IPC	Infection Prevention and Control
IPV	Intimate Partner Violence
ISCG	Inter Sector Coordination Group
ISNA	Inter-Sector Needs Assessment
IYCF	Infant and young child feeding
JPM	Joint Protection Monitoring
JRP	Joint Response Plan
KAP	Knowledge, Attitudes, and Practices
LPG	Liquified Petroleum Gas
LSD	Livelihood and Skills Development
MEB	Minimum Food Basket
MHPSS	Mental Health and Psychosocial Support
MPC	Multi-Purpose Centers
MPWC	Multi-PurposeWomen Centre
MSNA	Multi-Sector Needs Assessment
NCD	Non-Communicable Disease
NFI	Non-Food Items
NGO	Non-Governmental Organization
NPM	Needs and Population Monitoring
NRM	Natural Resource Management
PHNA	Public Health Needs Assessment
PSEA	Protection from Sexual Exploitation and Abuse
PwD	Person with Disabilities
REVA	Refugee Influx Emergency Vulnerability Assessment
RIMA	Resilience Index Measurement and Analysis
RRRC	Refugee Relief and Repatriation Commissioner
RUTF	Ready-to-Use Therapeutic Food
SEA	Sexual Exploitation and Abuse
SENS	Standardized Expanded Nutrition Survey
SoP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WFP	World Food Programmme
WFS	Women Friendly Space
WGSS	Women and Girl Safe Space
WHO	World Health Organization
WLCC	Women Led Community Centre

EXECUTIVE SUMMARY

August 2024 marked the seven years since the 2017 influx of Rohingya refugees from Myanmar to Bangladesh. As of October 2024, a total of 1,004,986 refugees (204,148 families)[1] were registered in the Cox's Bazar District of Bangladesh, residing in 33 camps in the Teknaf and Ukhiya sub-district (upazilas), as well as on Bhasan Char Island. In addition, 50,000 new arrivals from Myanmar are estimated to have entered the Cox's Bazar camps since late 2023.

The 2024 Inter Sector Needs Assessment (ISNA) reveals that food security for Rohingya refugees remains challenging, despite the provision of various forms of assistance. With households' average monthly income reaching less than BDT 5,000 compared to average expenditures (BDT 7,480),[2] most households remain heavily dependent on humanitarian food aid (69%). Some 73% of Rohingya households reported at least one source of income. However, among income-earners, only 35% can contribute to household income due to very low pay or irregular income activities. Only 15% reportedly accessed any form of skills or livelihood training and, of those trained, only 36% were able to use their acquired skills for income generation.

Worsening malnutrition for children is apparent through the Standardized Expanded Nutrition Survey (SENS) 2023[3], with wasting at a critical prevalence level of 15.1% increasing from 12.3% in 2022. Similarly, the prevalence of severe wasting nearly tripled, from 0.7% in 2022 to 2.0% in 2023. This explains the increase in admissions from January to August 2024, such that children aged 6-59 months with severe wasting showed a 20% increase and a 40% increase in moderate wasting compared to the same period in 2023. On the other hand, the results of the Public Health Needs Assessment (PHNA) 2024 showed 93% of the refugee households have access to primary health care facilities in the camps. While 49% indicated it required less than 15 minutes to reach a health facility and only 1% reported that it takes more than one-hour, 22% of respondents expressed they have had difficulty accessing health services in the last three months.[4]

The ISNA also indicates that most refugee households with children aged 3-18 are reportedly able to enroll their children in different learning facilities inside the camps (78%), while 22% of refugee households are unable to send any of their children to learning facilities.

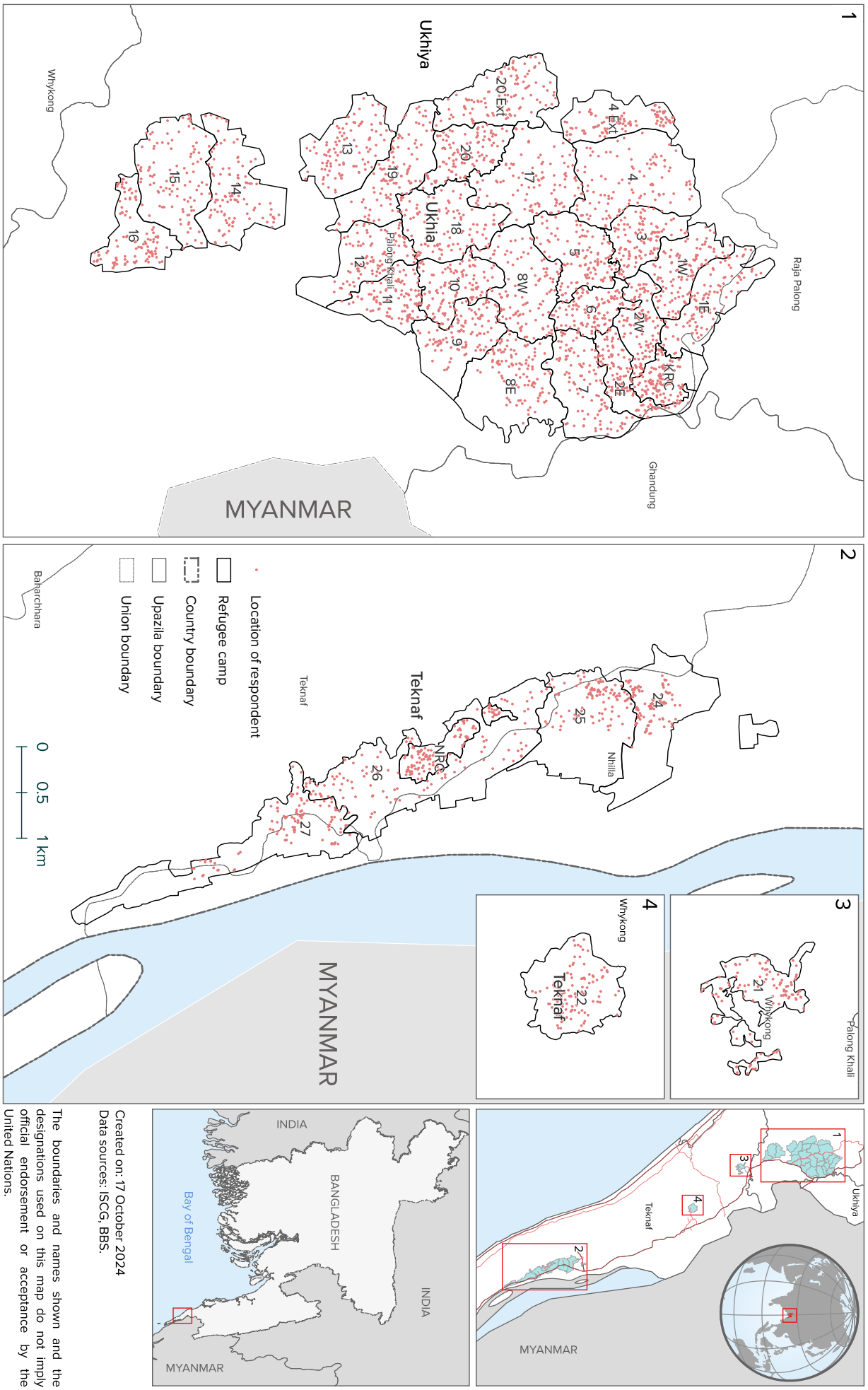
Safety and well-being are the among the most pressing concerns for refugees. Caused by the rise of organized groups in the camps, escalating violence – which includes serious physical assault, extortion, abduction, forced recruitment, intimidation, and killings – has severely impacted safety, security, and the physical and psychological well-being, particularly that of young people. Reports indicate that young children, adolescent boys and adult males are being forcibly recruited, intimidated, or manipulated to join organized groups in almost all camps. According to GBV-IMS Q1 report, Women and girls continue to be extremely vulnerable to gender based violence (GBV) with nearly half (46%) of households expressing an increase in safety concerns for women and girls. Intimate partner violence remains the most reported form of violence, followed by emotional abuse and denial of resources. Sexual violence remains the most underreported form of GBV due to fear or retaliation, stigma and cultural barriers.

Refugee households in the camps continue to rely on temporary, inadequate, and substandard shelters. Ninety-seven (97%) of refugee households still live in emergency shelters (primarily made of makeshift materials), while 2% live in collective shelters (less than 1% live in houses, tents, or unfinished/non-enclosed buildings). Despite efforts to provide all households with liquid petroleum gas (LPG) for cooking, almost one quarter (23%) of households still use firewood. Eighty-five percent (85%) of households report having sufficient water to meet their needs. There has been significant improvement in solid waste management with only 8% of households reporting visible waste in the vicinity of their shelters compared to 15% in 2023.[5] In addition, 84% of households are using the two-bin sorting system for more sustainable waste management and 87% of households report their waste is collected daily.

These and other findings are explored in detail across sectors in the following report, alongside the findings from cross-cutting themes, and youth working group to guide and inform the Rohingya Refugee Response going forward.

1. UNHCR (2024, October). Joint Government of Bangladesh – UNHCR Population Factsheet.
2. REACH (2023, December). Joint Multi-Sector Needs Assessment – Bangladesh Rohingya Refugee. Bangladesh MSNA Bulletin, December 2023.
3. UNHCR (2024, January). UNHCR Bangladesh Standardized of Nutrition Survey (SENS).
4. Health Sector Cox Bazar (2024) Public Health Needs Assessment in Rohingya Refugee Camps 2024-2025. PHNA 2025-2026
5. WASH Sector Cox's Bazar (2024). WASH | Rohingya Response

MAP 1: LOCATION OF SURVEY RESPONDENTS



Created on: 17 October 2024
Data sources: ISCG, BBS.

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

BACKGROUND

The camps in Cox's Bazar are overcrowded and situated in hilly, landslide-prone terrain, exposing refugees to significant risks and at times limiting their access to basic services. While the humanitarian community has stretched its resources to meet the needs of the refugees, the situation continues to deteriorate, with increasing social and security issues exacerbating the challenges. The Government of Bangladesh maintains that the presence of refugees is intended to be temporary, with return expected once conditions in Myanmar permit. However, the ongoing conflict in Myanmar, particularly in Rakhine State, may prolong this process.

In response to the information needs of the humanitarian operation, the 2024 Inter-Sector Needs Assessment focused on context-specific and programmatic data to inform the Joint Response Plan (JRP) for 2025-2026. The assessment highlights prevailing risks and vulnerabilities, including the cross-cutting themes of energy and environment, emergency preparedness, age and disability, accountability to affected populations, youth, gender, and protection from sexual exploitation and abuse.

The assessment was carried out by the ISCG, with extensive technical input from Sectors and Working Groups, and in partnership of IOM/NPM & UNHCR/ACTED. The assessment focuses exclusively on the situation of refugees living in the Cox's Bazar camps and is based on quantitative data collected from 27 August to 23 September 2024 across the 33 camps in Ukhiya and Teknaf. It covers six Sectors and two Sub-sectors (Food Security, Livelihoods and Skills Development, Education, Protection [including Child Protection and Gender-Based Violence], Shelter, Camp Coordination and Camp Management, and Water, Sanitation, and Hygiene), and brings in external data from surveys from the Health, Nutrition and Food Security sectors. The total sample size was 3,465 households, with results disaggregated by gender and age, and further disaggregation provided as needed. The assessment did not include a qualitative component except for references made from focus group discussions carried out by the Sectors to support the analysis.

The ISNA focuses on understanding the humanitarian needs and response gaps in the Cox's Bazar camps through a sector-specific needs analysis. Over the past years, several assessments have been conducted, and this data remains relevant to the current context. However, there are specific gaps that have been overlooked and thus, priority was given to collecting this information. In the analysis of the data, Sectors did not rely on the results of the ISNA survey alone but also triangulated and reinforced their understanding through secondary data sources. The assessment employed both the use of primary data (household survey) and secondary data (sector and thematic assessments) in its analysis of humanitarian needs, response gaps and vulnerabilities.

The data presented throughout the report is from the ISNA 2024 household survey unless otherwise referenced.

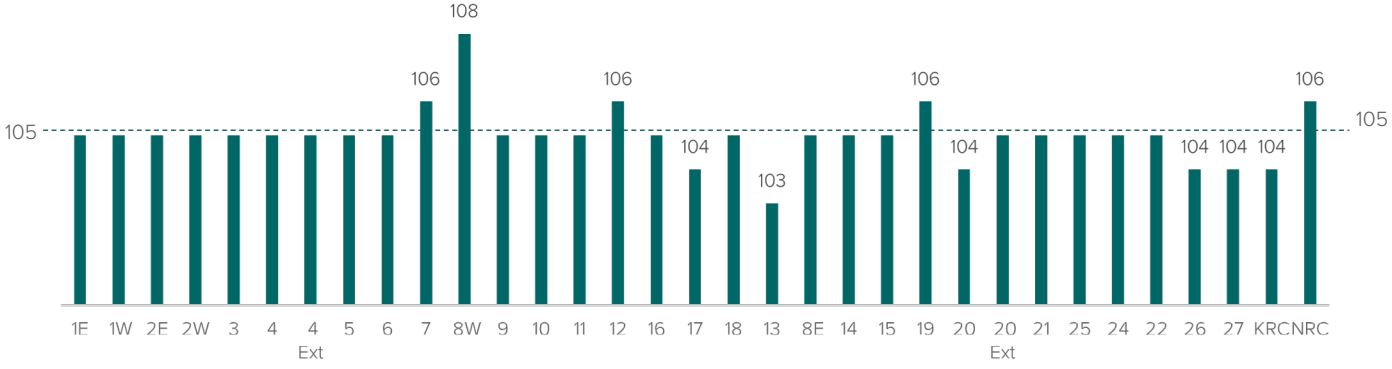
HOUSEHOLD DEMOGRAPHICS

Of the total Rohingya population living in Bangladesh (the majority live in the Ukhiya and Teknaf upazilas of Cox Bazar (969,096 of 1,004,986 individuals as of October 2024).[6]

The survey reached 2,731 (79%) households (HHs) in Ukhiya and 734 (21%) household in Teknaf. Most respondents were within the 25-40 age group (53%), followed by the 41-59 age group (23%), the 18-24 age group (13%), and those above 60 years old (11%). Fifty-seven (57%) of respondents were heads of households (female 50% and male 50%).

The average size of a Rohingya household (HH) is 5 individuals. The average age is 21 years, with 43% of household members falling within the 18-59 age range, 52% between 0-17 years (children) and 5% aged 60 and above (elderly). Most respondents surveyed (2,013 people or 58% of Rohingya households) were households with youth members.

Graph 1: Number of HH respondents per camp (total respondents 3,465 HH) ----- average sampling size per camp



6. UNHCR (2024, October). Joint Government of Bangladesh – UNHCR Population Factsheet.

Of Rohingya households surveyed, 18% were heads of households, 15% spouses, and 60% were children. Many households also included extended family members such as grandchildren (3%), children-in-law (2%), grandparents/ parents/parent-in-law (1%), siblings and other relatives (1%), and guests (0.6%).

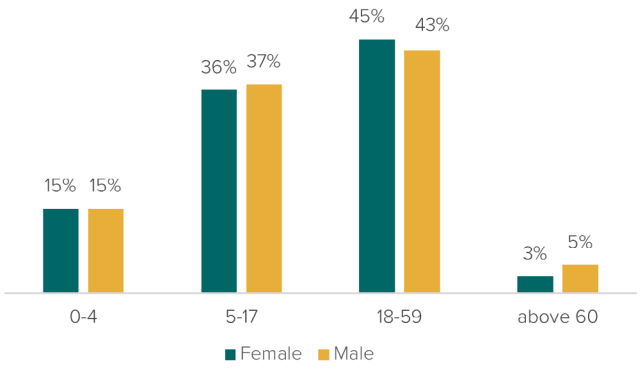
While the number of persons with specific needs is underreported in the camps, the Joint Government of Bangladesh and UNHCR registration (as of October 2024) indicates at least 6.21% of refugees are persons with at least one specific need, as shown right (see table 1).

Table 1: Number of refugees with specific needs[7]

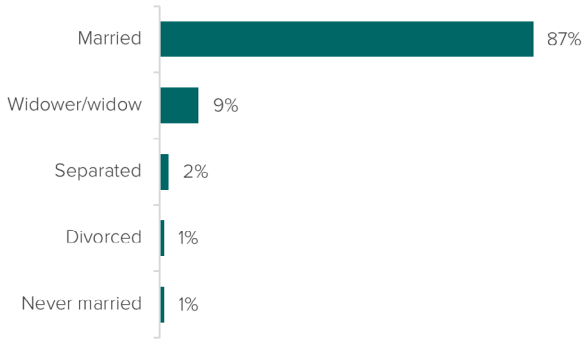
Specific needs	Number (individuals)	Percentage (%)
Persons with disability[8]	28,070	3%
Single parent/caregiver	15,710	2%
Legal & physical protection needs	5,327	1%
Serious medical condition	3,120	0.3%
Unaccompanied/separated children	2,172	0.2%
Other specific needs	1,895	0.2%
Children at risk	1,715	0.2%
Older person at risk	1,652	0.2%

Note: Figures refer to the whole population of the Cox's Bazar camps, not the survey respondents.

Graph 2: Age and gender distribution of household members



Graph 3: Marital status of head of households



7. Government of Bangladesh - UNHCR Population Factsheet, October 2024.
8. Government of Bangladesh and UNHCR are jointly working to register all persons with disability (PWD) in the camps and this number will likely increase as the verification of PWD is on-going.

HIGHLIGHT OF FINDINGS FOR CROSS - CUTTING THEMES

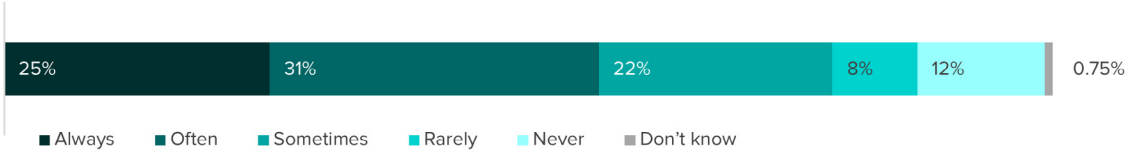
AGE AND DISABILITY

As revealed in the ISNA 2024, there are around 12% Rohingya individuals who have at least one disability. Difficulty in walking and climbing steps is the highest reported disability at 7.2%, followed by difficulty in seeing even after wearing glasses at 4.6%, difficulty with self-care at 4.4%, difficulty remembering or concentrating at 3.9%, difficulty hearing even after wearing a hearing aid at 2.8%, and difficulty understanding or being understood at 2.14%. At present the Joint-Government of Bangladesh – UNHCR refugee population statistics only reflects 3.02% persons with disability and 4% older persons, showing a gap in comparison to ISNA findings. This issue is gradually being addressed through rigorous and targeted initiatives to identify/update persons with disabilities by 2025. Among persons with a disability, at least 79% are reporting some challenges in accessing humanitarian assistance, such as education, health services, shelter support, or other kinds of assistance (See graph 4).

Recommendations:

- Design inclusive projects and ensure mandatory targeting for Persons with Disabilities (PWD).
- Increase capacity building and empowerment of PWD.
- Include PWD in decision making.
- Improve the physical accessibility of facilities.
- Ensure the active consultation of diverse groups including PWD in all project phases.
- Produce accessible information materials for all activities and ensure communication strategies are also accessible.
- Conduct sector-specific gap analyses on inclusion and periodic assessments based on recommendations therein.

Graph 4: Persons with disabilities who experience difficulties in accessing assistance



ACCOUNTABILITY TO AFFECTED POPULATION (AAP)

Most (72%) households reported being aware of how to lodge complaints through formal Complaint and Feedback Mechanism (CFM) channels (operated by humanitarian organizations), while 19% still resort to informal channels (not operated by humanitarian organizations). Among those who submitted complaints or feedback, 57% received a response, and of these, 17% expressed dissatisfaction with the response and outcomes. This low response rate (43% not having received a response) represents a significant gap and thus, the need to strengthen the existing mechanisms. Regarding the types of channels, the most popular types of channels used by the households were face-to-face interaction (including household visits) with humanitarians (45%), help/information desks (35%), complaint boxes (13%) and hotlines/phone numbers (6%) (See graph 5).

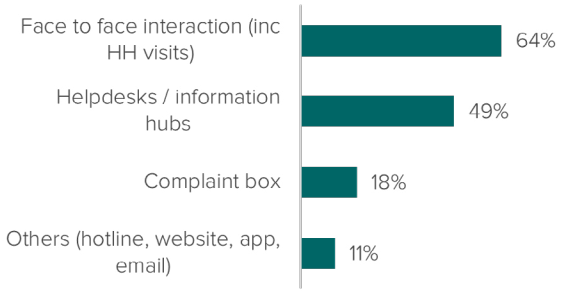
Approximately 19% of Rohingya households expressed preference to use informal channels such as CiCs (80%) and community leaders (55%) over established formal channels (See graph 6).

On participation, 92% of the households felt (always or most of the time) that their opinions on humanitarian services and assistance are considered by humanitarian workers. It is also notable that 97% of Rohingya households felt that they are treated with respect and dignity by aid workers.

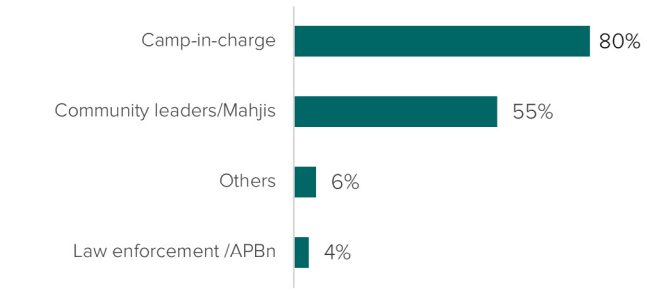
On receiving information, most Rohingya households expressed satisfaction with the information provided about humanitarian services, with 97% reporting that they receive adequate information. Furthermore, 99% indicated that they find the information easy to understand, highlighting effective communication efforts in ensuring accessibility and clarity.

About 94% of households preferred receiving information on humanitarian services through volunteers, followed by Majhis/community leaders (77%) and humanitarian workers (66%). Other notable information sources include CiC offices (51%) and family members, relatives, or neighbors (also 51%). This highlights the importance of enhancing the capacity of volunteers and staff engaged at camp-level.

Graph 5: Rohingya HHs preference when using formal channels for complaints & feedback



Graph 6: Rohingya HHs preferences when using non-formal feedback channels



Recommendations:

- Strengthen formal channels (face-face, household visits, help/info desks) for complaints feedback/ response.
- Strengthen capacity of staff, volunteers and community leaders (including Majhis, religious leaders, women, youth and PwD).
- Encourage standardize common messaging (4 languages, audio and visual).
- Strengthen advocacy with CiC and community leaders to refer complaints/feedback to appropriate channels.
- Rationalize and strengthen CFMs with common reporting system.

ENERGY AND ENVIRONMENT (EEN)

Almost one quarter (23%) of Rohingya households are still using firewood among their sources of cooking energy despite the regular provision of LPG. This practice presents risks of deforestation, heightened risks of GBV, and social tensions between Rohingya and host communities.

Fifty-seven percent (57%) of households expressed lack of proper lighting at nighttime, restricting movement of household members during the evening. Some 32% of women and girls reporting not feeling safe using communal latrines. This is partly due to the functionality of solar infrastructure, including solar streetlights and grids; there are at least 24,000 solar streetlights installed in the camps but only 51% are fully functional.[9]

There is need to upscale climate adaptation and mitigation to reduce the impact of climate change in the camps. In 2024, heatwaves and the monsoon resulted in fatalities and significant damage to shelters and facilities, often as a result of slope failure incidents. At the community level, it is concerning that 87% of households reported never having had any involvement in awareness raising on climate change. Further, only 8.4% of respondents reported having a good understanding of the impacts of climate change (36% had some understanding and 55% had no understanding). Limited knowledge on this vital topic could explain some prevailing environmental issues in the camps, such as negative waste practices, uprooting of plantations, and ongoing firewood usage.

Recommendations:

- Engage community in climactic and environmental issues (green skills development, maintenance needs of solar infrastructure and environmental stewardship).
- Strengthen nature-based solutions for DRM and NRM.
- Strengthen/Implement Blue-Green Network approach.[10]
- Prioritize water resource sustainability.[11]

EMERGENCY PREPAREDNESS AND RESPONSE (EPR)

Approximately 19% of the land in the 33 camps is at high risk of landslide, with an estimated 39,000 individuals residing in perilous locations. An additional 18% of the camp area is flood-prone and shelter approximately 47,000 individuals.

Moreover, 97% of the households are at high risk of fire and cyclones, as most refugees live in shelters made of flammable material (predominantly bamboo and tarpaulins), which cannot withstand sustained winds of over 60 km/h.[12]

It is also important to note that the coastal areas of Cox Bazar, including Teknaf and Ukhiya, face significant threats of strong cyclones during the twice-annual cyclone season

9. NPM (2024). Energy and Environment Solar Light Monitoring Dashboard - Solar Light Dashboard.
10. Blue-Green approach aims to systematically address DRM and natural resource management, a blue-green network approach is appropriate for an urban-like setting of the Rohingya refugee camps. By identifying landslide and flood risks, and prioritizing Site Development activities, an integrated approach is necessary, addressing watershed management, and overall water and land management needs.
11. Reduce extraction of groundwater especially in agricultural activities in the host communities, from simple practices as watering at dawn or dusk to reduce evaporation, to more complex methods as solar irrigation. Promote rainwater harvesting during the monsoon season in the camps to use for homestead gardens after the monsoon season.
12. ISCG (2024). Landslide Risk Prevention and Mitigation – Advocacy Note. Please contact ISCG's EPR Unit for details.

on the Bay of Bengal, which puts the camps at heightened risk to flooding, landslides, salt intrusion. Drought is a major concern during the dry season, particularly in the Teknaf camps which do not have sufficient water reservoirs and are reliant on surface water.[13]

Household resilience is of special concern during and after emergencies, given refugees' high dependence on humanitarian assistance and their insecurity of tenure; indeed, 88% of households having no written tenure document in respect to the land on which they built their shelter.

On a positive note, 97% of Rohingya households practice preparedness mitigation measures, such as tying down shelters to withstand strong winds, and preparing food and water stocks (See graph 7). However, with the urgent need to protect households from different disasters, a shift towards temporary safer shelters is needed for those in high risks or danger areas.

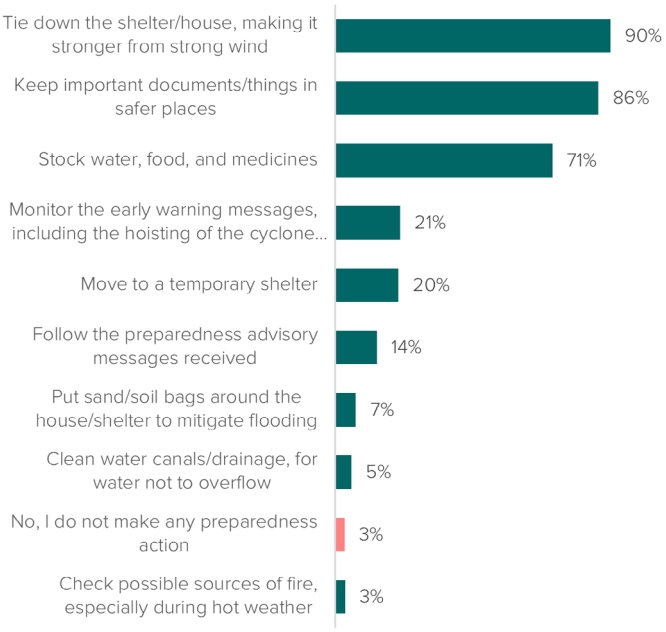
While the majority of the Rohingya households preferred receiving information from volunteers (85%) and Majhis/ community leaders (65%). Refugees mainly rely on Majhis as their contact point during emergencies.

Through efforts to increase awareness on emergencies, 34% of respondents indicated participation in capacity-building activities such as 10% in simulation/drills, 18% in disaster awareness-raising and 3% in hazard and risks analysis.

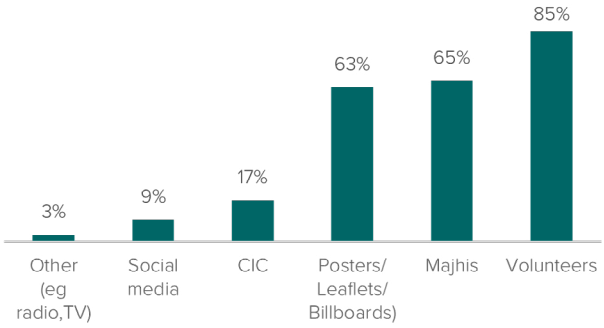
Recommendations:

- Risk informed comprehensive site planning and development.
- Disaster and climate resilient shelters and facilities for relocation / evacuation.
- Increase household coverage with EPR basic measures and coping mechanisms.
- Improve policies and guidelines (SOP, allocated and harmonized contingency coverage, regulations on security of tenure/rental issues, policy on evacuation in HC).
- Inclusion of DRR/DRM/EPR in education curriculum.
- Alignment and inclusion in government policies and plans.
- Improved capacity of volunteers and community leaders (eg. Mahjis).
- Inclusive and people centered, end-to-end early warning system for all hazards.
- Strengthen ERP/DRM coordination mechanisms.
- Partnerships and collaboration with government line agencies (FSCD, BMD, CPP, DRRO, RRRC).
- Strengthen communication/dissemination tree.

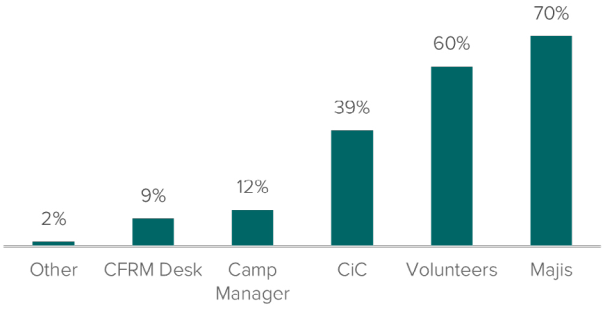
Graph 7: Rohingya HHs practicing mitigation measures during natural disasters



Graph 8: Rohingya HHs main sources of information



Graph 9: Rohingya HHs immediate contact during disasters or emergencies



13. Government of Bangladesh (2024). Bangladesh Delta Plan 2100.

PROTECTION AGAINST SEXUAL EXPLOITATION AND ABUSE (PSEA)

There is a need to strengthen community knowledge on reporting mechanisms for sexual exploitation and abuse (SEA). Approximately 59% of Rohingya households possess knowledge and awareness of the available reporting mechanisms. About one quarter (26%) have received awareness sessions in 2024, representing a 10% increase from 2023. These figures are consistent across gender and age groups. Most Rohingya prefer to report SEA cases to their Camp-in-Charge (72%), women and girl safe spaces (43%) and Mahjis (38%) (see graph 10).

While most households (96%) are confident in their ability to report misconduct, 4% are hesitant. Among hesitant households, 57% (62% women and 38% men) do not know what constitutes misconduct or reportable behavior, and 29% do not know where to make a report. A small portion of households (3%) agree that it is acceptable for individuals to engage in exploitative relationships with humanitarian workers for material favors, or for humanitarian workers to request favors in exchange for assistance (1.4%), suggesting a small but material vulnerability where exploitative relationships may be normalized and accepted.

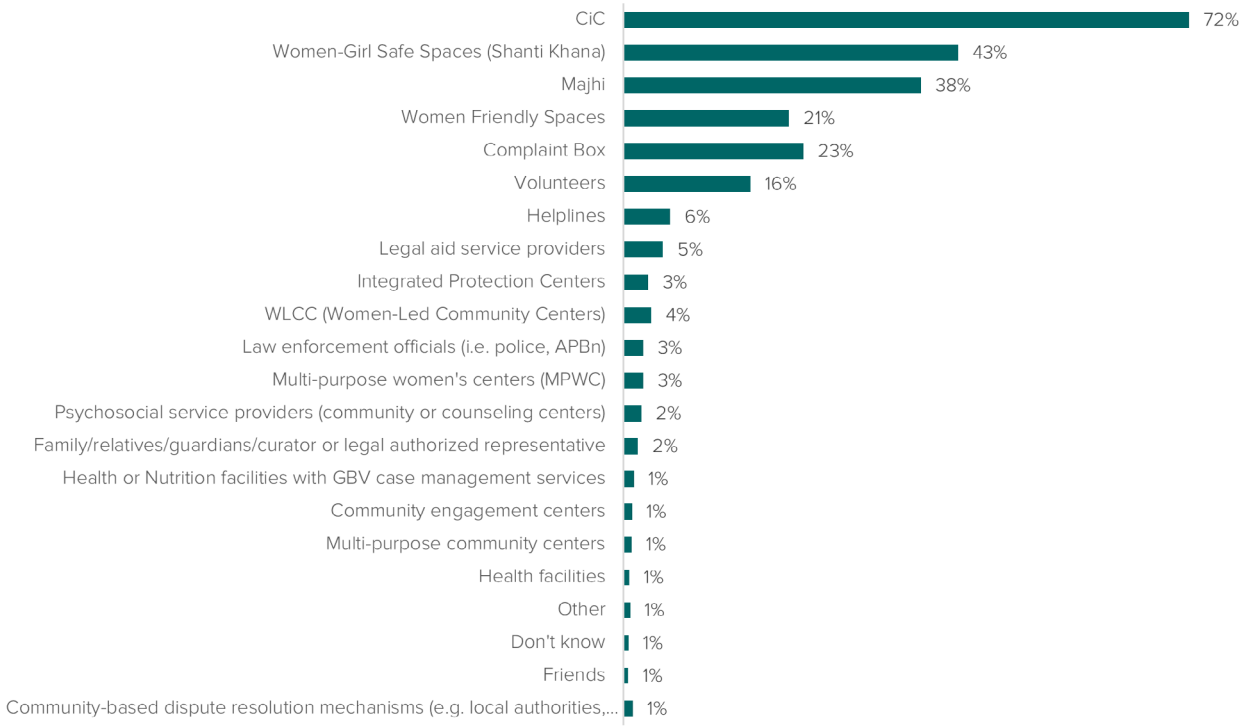
A gender analysis of the barriers to reporting reveal concerning disparities: women are significantly less likely to know where to report misconduct (26% of women versus 33% of men). This gaps suggest women may be exposed to higher risk of exploitation and abuse than men due to lack of knowledge.

The Rohingya households surveyed would like to receive PSEA information through face-to-face communication with aid workers (71%), volunteers (48%) and door-to-door visits (37%). These findings show that the community prefers direct engagement as opposed to the generic sharing of information, highlighting the need for a new communication strategy.

Recommendations:

- Staff capacity building and refreshers including senior management.
- Ensure PSEA information and initiatives are disseminated at all levels within the organizations.
- Develop key PSEA messaging aligned with UN policy and standards and PSEA network policies.
- Strengthen awareness raising initiatives with emphasis to reporting mechanisms at community level across all gender and age groups.
- Strengthen reporting mechanisms including addressing barriers faced by women in reporting misconduct.
- Develop PSEA materials that are culturally sensitive, understandable, and appropriate and circulation at all distribution points.
- Ensure reporting mechanisms are tailored to community preference, simple and accessible.
- Regular assessments to monitor effectiveness.
- Inter-agency risks assessments.
- Engagement and capacity building on PSEA to government partners including CiCs and APBn.
- Engage with CiCs, Majhis and volunteers to disseminate PSEA information.

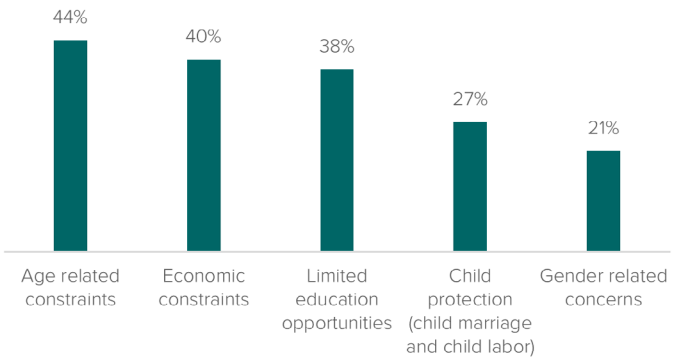
Graph 10: Rohingya households' preferred ways to report PSEA or raise sensitive issues such as inappropriate behavior



YOUTH[14]

Rohingya youth between 15-24 years old represent a fast-growing population, comprising 20% of people in the camps. However, the youth continue to bear the disproportionate impacts of their prolonged displacement with a lack of age-appropriate opportunities leaving them exposed to various protection risks. In school, education sector noted a sharp delay of children age 13-18 enrolled in learning facilities. The sector noted the main reason for not attending school include age related & economic constraints (see graph 11). Nearly 90% of youth reported not being enrolled in any form of skills development training or education, with limited age-appropriate opportunities and economic constraints as the main barriers, this is even more pronounced for female youth. Restricted access to skills development and livelihoods leaves over 90% of refugee youth without income-generating opportunities, with women and youth with disabilities facing even greater challenges due to social stigma, mobility constraints, and limited accessible opportunities.[15] As a result, less than 1% of youth reportedly contribute to household income, engagements which are often limited to unstable, informal labour with little job security - indeed, 48% of those contributing to HH income are engaged in casual or daily labour, 16% in an employer-employee relationship, 13% in self-employment, and 19% in cash-for-work or volunteer roles. As a result, many are forced into adverse coping mechanisms, including early marriage, drug abuse, unsafe migration, and forced recruitment.

Graph 11: Top 5 reasons Rohingya youths are dropping out of school



Over 27% of households with youth members expressed that they are experiencing psychological distress due to trauma, displacement, and the challenging conditions in the camps. According to the Knowledge, Attitude, Perception (KAP) Survey on Mental Health and Psychological Issues among Adolescents and Youth (2024), two in every five young people (42%) from the Rohingya camps in Bangladesh reported knowing someone with mental health issues severe enough to pose challenges to daily functioning. Additionally, 8% of Rohingya youth in the camps believe they have mental health issues, while 6% act as caregivers to someone experiencing mental health challenges. Young people cited substance abuse, such as drugs and alcohol (89%), external stressors (70%), and genetic inheritance (21%) as the main causes of mental health challenges.[16] The results highlighted that external stressors are primarily linked to their situation in the camps, including family problems and unemployment.

Refugee youth remain on the margins of humanitarian programming and largely excluded from decision-making processes, with their lack of inclusion contributing to negative coping practices.[17] Most (72%) household youth expressed a lack of opportunities to contribute to their community and participate in leadership roles. Furthermore, most (87%) have not been involved in the planning, implementation, or monitoring of humanitarian activities, highlighting a missed opportunity to leverage their potential.

Table 2: Reasons why Rohingya youth do not feel safe

Risks	% of households with youth members (n-2,013)
Fear of violence	67%
Uncertainty of the future	58%
Insecurity at night due to lack of lighting	42%
Lack of access of legal protection	32%
Psychological distress	27%
Gender-based violence	16%
Discrimination and stigma	17%
Other (insecurity due to statelessness, lack of privacy, limited economic prospects, unhealthy living conditions, dependence on humanitarian aid, child marriage, food insecurity, trauma)	25%

The most common barriers to participation included lacking the requisite skills (59%), the absence of any means to contribute (30%), and concerns about being disregarded or feeling unsafe (26%). These findings underscore systemic barriers to effective youth decision-making and meaningful and safe youth engagement, emphasizing the need for environments more conducive

14. The youth members are interviewed for ISNA, for questions related to the youth. For the Youth Working Group 's full report, please contact the Youth Working Group through Youth Working Group webpage.
15. NRC (2023). Ready to learn, eager to learn: a youth-led market and wellbeing assessment in Rohingya camp. - Youth-Led Assessment Report.
16. UNFPA (2024). Survey on the Knowledge Attitudes, and Perceptions (KAP) of Mental and Psychological Issues among Adolescents and Youth in Rohingya Refugee Camps. – MHPSS Survey - Summary of Findings.
17. NRC (2022). What About Us? Youth Inclusion in the Rohingya Response: a youth-led assessment in Rohingya camps. - Youth-led Assessment Report.

to leadership development among youth. The lack of investment in developing interpersonal skills among the youth further limits their participation, as more than 80% of surveyed youth reported not receiving life skills training, including communication, problem-solving, or decision-making.

Of the individuals contributing to household income through some form of livelihoods activity, 5% are aged 14-18 years. Every year, it is estimated that around 27,000 young individuals will turn 18 years old,[18] and thus, will start looking for income sources. The demand for skills development and livelihood opportunities will continue to rise and the lack of available income sources in camps may expose the youth to protection risks.

Recommendations:

Sector specific recommendations for the youth:

- Education: access to alternative and flexible learning pathways, ensure life-course approach.
- Livelihood: gender sensitive market relevant skills training, transition to safe-income opportunities, development of 'green' livelihoods.
- Health: health promoting youth needs, sexual education, SRH and MHPSS.
- Protection: define unique risks and needs to the youth, safe space for young people, safe channels to voice peace and security concerns.

CCT recommendations for the youth:

- Services adapted to age, gender, disability needs to address youth specific challenges.
- Mechanisms for safe and meaningful engagement of youth in leadership, participation and decision making.
- Mainstreamed youth age-gender in data.
- Cross sector collaboration to respond to youth needs.
- Peer to peer learning to strengthen youth networks.
- Social cohesion and peacebuilding.
- Youth led initiatives.

GENDER IN HUMANITARIAN ACTION (GIHA)

Women remain in a disadvantaged position both in the household and the community. The significant disparity on access to income sources for women across all camps indicates gender based economic challenges and unemployment. This difference holds true to other areas as well, such as access to skills training and livelihood. Despite a higher number of women trained both in 2023 and 2024 compared to men, only 8% of these women of working age (18-59) are now engaged in some form of income-generating activity. In education, there is a significant drop in the number of children accessing learning facilities from age 13, with only 8% of girls (age 15-18) able to remain enrolled.

Recommendations:

- Contextual gender analysis on risks and vulnerabilities of women and girls in comparison to men and boys.
- Conduct analysis on participation and leadership for women in the camps.
- Strengthen interventions on gender norms related unpaid domestic work, equitable roles, and behavior change programming.
- Implement GBV responsive interventions across sectors, including CFRM and safety among men and boys.
- Consistent gender mainstreaming (integrated & targeted approaches).
- Engage Rohingya women's network in validating data and seek their inputs to recommendations.

18. Miah, Abu Said & Titumir, Rashed & Shahan, Asif & Islam, Kazi & Bhuiyan, Md Imran Hossain & Morshed, K.A.M. & Faruque, ABM & Rashid, S. (2023). Rohingya Crisis Response in Bangladesh Do we Need a Strategic Shift from the Current Approach? Download citation of Rohingya Crisis Response in Bangladesh Do we Need a Strategic Shift from the Current Approach?

HIGHLIGHT OF FINDINGS FOR SECTORS

FOOD SECURITY

Efforts to provide diversified food sources have shown positive results for the 16% of Rohingya households who independently sustained their homestead gardens after the conclusion of partner activities. Despite this, 24% of Rohingya households could not afford food despite receiving regular food assistance.

This analysis combines data from both the Refugee Influx Emergency Vulnerability Assessment (REVA)19 -7 and ISNA 2024.

Vulnerability[20]

The REVA-7 (2024) reported that, as of late 2023, 86% of Rohingya households had high vulnerability, an increase of 3% from 2022, while 11% had moderate vulnerability, a decrease of 1% from 2022. From 2017 to 2023, vulnerability consistently increased by at least 4%, despite a slight decrease of 3% in 2021 (see Graph 12). Between 2022 and 2023, only 10% of Rohingya households experienced a decrease in vulnerability, 14% experiencing increased vulnerability and 77% retaining the same vulnerability. The major driver of household vulnerability was expenditure below the minimum food basket (MEB), which underscored the need for more livelihood opportunities for households to mitigate the impact of ration cuts (2023-2024) which brought the food ration from USD 12 to USD 10 to USD 8 before their gradual restoration in Q3 2024.

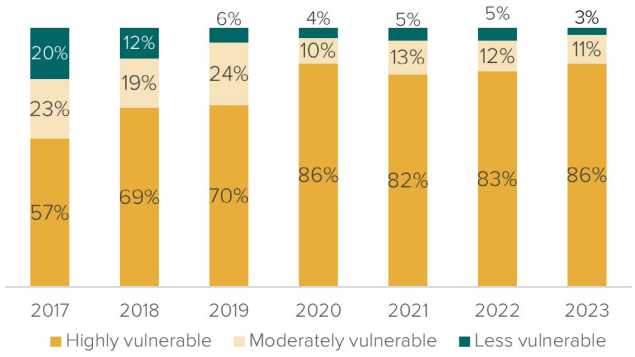
Food access, availability, and coping mechanisms

Per the REVA-7, nearly a quarter (24%) of Rohingya households in Cox's Bazar could not afford food despite receiving regular food assistance. In addition, 70% have poor or borderline diet quality. The number of households that managed to have only 2 meals per day increased from 2% in 2022 to 5% in 2023. The ration cut in 2023 also contributed to increased challenges for household households were shown to have acceptable food consumption.[21]

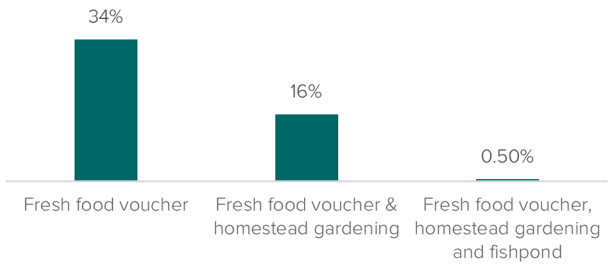
Rohingya households face continuing difficulties in securing sufficient food and income, forcing many to adopt negative coping mechanisms. The top four strategies used were 1) reducing consumption of more expensive foods (67%); 2) borrowing food or relying on aid from others (29%); 3) decreasing the number of daily meals (8%); and 4) limiting adult food intake to prioritize children (9%). Selling relief items to buy other necessary items remains prevalent at 71% in both 2022 and 2023 mainly to purchase fish, fresh vegetables and medicines and cover treatment costs. In 2023, almost all (93%) Rohingya households reported using at least one coping strategy,[22] up from 68% in 2022, indicating a growing reliance on negative coping mechanisms as food security challenges persist.[23]

Rohingya households rely on humanitarian assistance to alleviate their vulnerability. From 2017-2023, food assistance continued to be provided to all refugee households despite funding challenges and the unavoidable ration cuts from March 2023 to August 2024. Efforts to diversify food sources have been deployed for several years, but could not be made available to all refugees, with only the most vulnerable households targeted. ISNA survey results showed, only 34% (the most vulnerable) receive additional fresh food e-vouchers (FFV). Alternative food sources, such as homestead gardening, reached 47% of households while fishpond production reached less than 1 percent (a mere 0.3%). Some households had to access one or two types of assistance, however, with 16% benefitting from both FFV and homestead gardening support, and 0.5% receiving FFV, plus homestead gardening and fishpond production assistance (See Graph 13).

Graph 12: Trends of overall household vulnerability



Graph 13: Rohingya HHs with access to two or more alternative sources of food



19. WFP (2024, July). Bangladesh Refugee Influx Emergency Assessment (REVA-7).
20. Vulnerability is a composite WFP corporate indicator that measure the ability of the household to meet the essential needs triangulated with adopted coping strategies and food security status. This vulnerability index discounts humanitarian assistance. (Source: REVA 7, linked above).
21. Ibid
22. Coping strategies include borrowed food or relied on support from friends and neighbors, reduced portion sizes or meals in a day (food consumption based) while others resort to withdrawing children in school, asset depletion and engaging in emergency measures such as begging to name a few. (REVA-7)
23. FAO (October, 2023). Resilience Index Measurement and Analysis (RIMA 3). FSS | FAO's Resilience Index Measurement and Analysis (RIMA) study Round-3 report.

Despite challenges, 67% of Rohingya households have managed to sustain homestead gardening for more than one year since the initiative started and, of these, 72% expressed that the gardens somewhat provided additional food, such as vegetables, for their regular meals. However, 50% household beneficiaries production capacity decreased over time due to weather and climatic events, poor soil quality, late distribution of inputs, and the lack of continued technical support. Among those engaged in fishpond production (0.3%), 75% indicated that the project was somewhat helpful and 25% a little helpful.

Rohingya households who are fully reliant on humanitarian assistance cited the following reasons for being unable to access FFV, homestead gardening or fishponds, namely 1) not being included in the selection or not meeting the criteria (66%), 2) no space for gardening or access to fishponds (26%), 3) not aware of the project (5%), and 4) not interested (1%).

Household resilience[24]

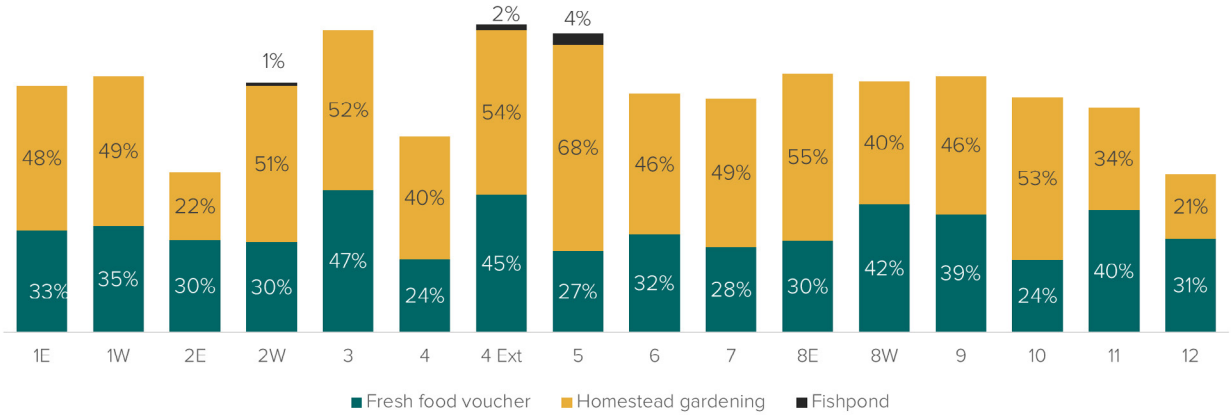
Per the REVA 7, the average resilience index of Rohingya households dropped by 7 percentage points, from 42% in 2022 to 35% in 2023. Households practicing homestead gardening were found to have higher resilience compared to those households not practicing homestead gardening.[25] More than half of Rohingya households engaged in homestead gardening had a lower resilience than the community average, thus requiring special attention.

Access to education, markets, skills development training (including, homestead gardening) and use of improved technology for homestead production were shown to have a significant positive impact on resilience.

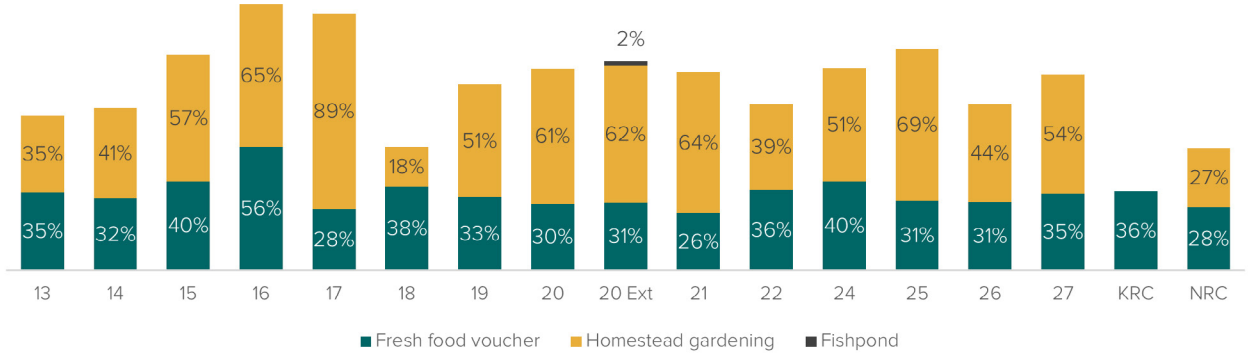
Recommendations

- Advocate for expanding alternative food sources (e.g. fresh food vouchers, fishponds, homestead gardening) to reach all Rohingya households to ensure diversified food sources and access to micronutrients, thereby improving their self-reliance.
- Ensure close follow up on trainings and technical support to families engaged in gardening and fishponds, and timely provision of inputs.
- Consider the risks associated with weather changes, hazards, and poor soil quality when partners design or improve interventions.

Graph 14: Rohingya HHs per camp with access to fresh food voucher, homestead gardening and fishpond (Camp 1E - Camp 12)



Graph 15: Rohingya HHs per camp with access to fresh food voucher, homestead gardening and fishpond (Camp 13 - NRC)



**Note: Households can receive multiple forms of assistance at the same time. For instance, a single household may be enrolled both in both fresh food voucher and homestead gardening programmes.*

24. Resilience is the ability of households and communities to cope with and recover from challenges such as natural disasters, economic downturns, or social conflicts. (RIMA 3, 2024)
25. FAO (2023). Resilience Index Measurement and Analysis (RIMA 3). FSS | FAO's Resilience Index Measurement and Analysis (RIMA) study Round-3 report.

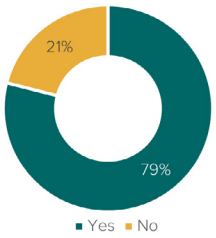
LIVELIHOODS AND SKILLS DEVELOPMENT

Most (79%) of Rohingya households have one income source, but only 35% among them are able to contribute to household income. Significant gaps remain for linking Rohingyas, especially women, with economic opportunities.

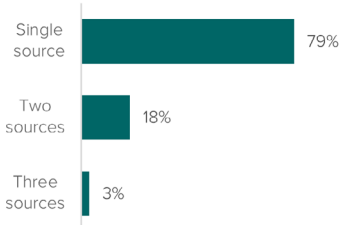
Access to livelihood and other income sources

Access to livelihoods and other sources of income in the camps is crucial to help Rohingya households build resilience. Efforts to reinforce the local market economy in the camps have been initiated in the past years, albeit to a very limited degree, through small-scale activities, such as cash-for-work, literacy training, and skills development. As of 2024, ISNA results showed 79% of Rohingya households reported at least one source of income, but 21% lacked any income source (excluding food rations). Of the working age household members (18-60 years old), only 35% are able to contribute to household income (see graph 17). Out of these, 92% were men while only 8% were women.

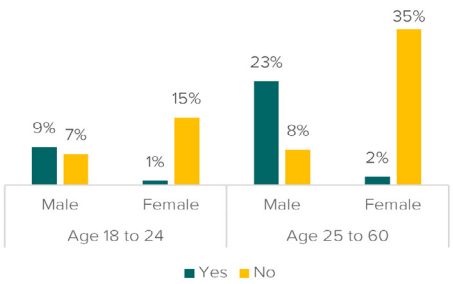
Chart 1: Rohingya HHs with members engaged in any income generating activities



Graph 16: Rohingya HHs with multiple sources of income

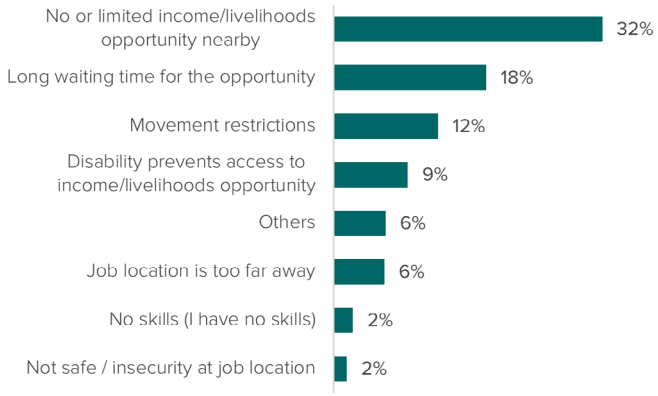


Graph 17: Rohingya HHs members contributing to household income by age and gender

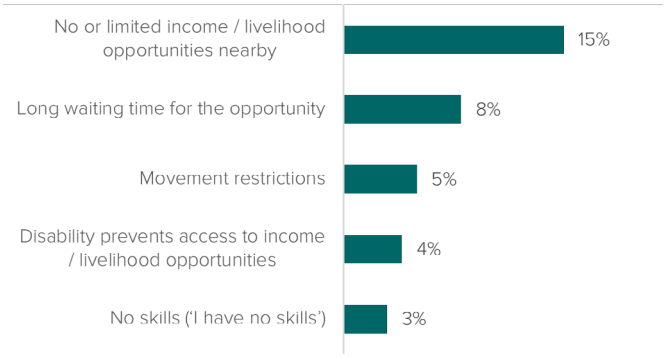


Forty-five percent (45%) of Rohingya households expressed they did not experience barriers in accessing income or livelihood opportunities in the past 6 months prior to the survey. However, accessing income or livelihood opportunities remains a challenge for the majority of the Rohingya households, including women, due to limited access to livelihoods, long wait times for opportunities, and movement restrictions (see graph 18).

Graph 18: Households barriers to accessing income opportunities



Graph 19: Women's barriers to accessing income opportunities



Gender disparity

The ISNA survey showed that 8,255 working age household members, only 35% were found to be contributing to household income. The majority were men (92%) with women comprising only 8%. Among 18–24-year-olds, 90% of young men had access to livelihood activities versus only 10% of young women with similar discrepancies within the 25-60 age group (93% of men versus 7% of women). (see graph 19).

Results from the 2023 Joint-Multi Sector Needs Assessment (J-MSNA) also showed that 40% of Rohingya households lacked nearby income and livelihood opportunities, underscoring the geographical and infrastructural constraints that limit access to post-training support to livelihoods programme beneficiaries. Women and youth also faced limitations in accessing both skills development and livelihood opportunities due to safety concerns, poor quality of education, and gender-related concerns. Though few households reporting such barriers in the 2024 ISNA, this evidence still indicates the presence of serious obstacles that can limit access to opportunities and perpetuate cycles of exclusion.

Income diversity

Seventy-nine percent (79%) of Rohingya households reported only one source of income, while 21% had diversified income sources. The majority (54%) of the households had an income of less than 5,000 BDT per month, which is an increase from 3,000 BDT in 2023 (MSNA, 2023). The financial situation of households remained constrained, particularly considering the cost of living and the essential spending needs of household members. Per 2023 J-MSNA, a Rohingya household needs at least 7,480 BDT to cover minimum household expenses.[26] This persistent income gap leaves many households struggling to afford even basic items, exacerbating their reliance on humanitarian assistance and contributing to ongoing financial hardship.

Table 3: Average income of Rohingya HH per month

Income group	% of household
Above 10,000 BDT	9.1%
7,001 – 10,000 BDT	14.3%
5,001 – 7,000 BDT	22.2%
3,001 – 5,000 BDT	32%
1 – 3,001 BDT	22.6%

Income sources

Of the 79% of Rohingya households with income sources, 47% are reliant on casual or daily work, an increase from 38% in 2023, while 16% report having their own small business or trade. This indicates a growing reliance on unstable source of income that may include informal activities and could potentially expose households to protection risks such as exploitation. Below are the types of work of Rohingya households in the camps (see graph 20).

Graph 20: Sources of income for Rohingya HH

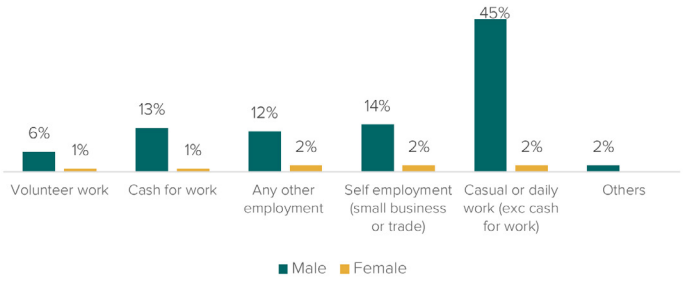
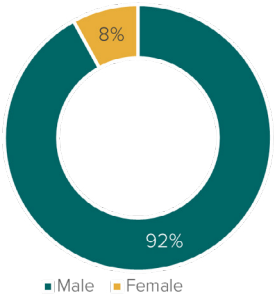
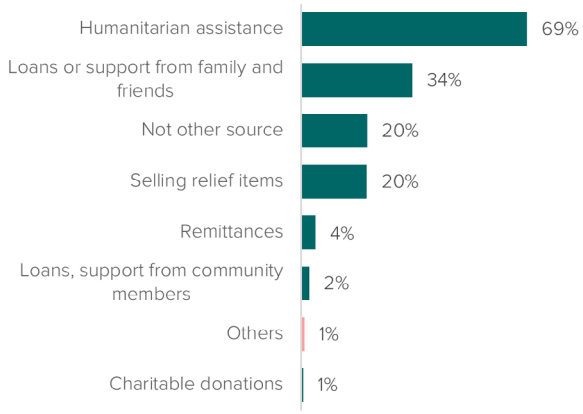


Chart 2: Rohingya HH members with income sources – age 18 above



Graph 21: Other sources of cash flow among Rohingya HHs - % response



Reliance on only one income source (79% of the Rohingya households) compounds vulnerability. Only 18% of Rohingya households have at least two income streams and a mere 3% have three or more income streams (see graph 16). This concentration of income dependency not only limits financial resilience but also increases households' susceptibility to economic shocks, thereby exacerbating their precarious situation. The findings underline the critical need for interventions that both expand employment opportunities and promote economic diversification, particularly for women and youth, to reduce income concentration and vulnerability.

Cash flow

Humanitarian assistance remains the main source of cash flow for 69% of households. While 20% still resort to selling relief items received to generate additional cash to meet household needs. Getting loans or support from family and friends (34%) and from other community members (2%) are also common, which also brings households into debt and in some cases involves paying interest.

26. REACH (2023). Joint Multi-Sector Needs Assessment. https://dashboards.impact-initiatives.org/BGD/msna/2023/.

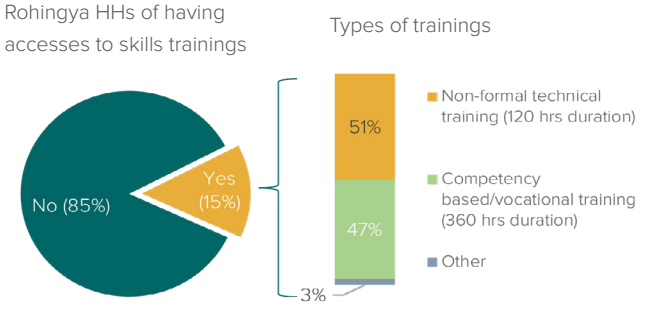
Debt

Eleven percent (11%) of Rohingya households reported that their debts have reduced from the previous year while 37% reported being debt-free. Some 31% expressed that their debts are increasing, while 21% reported their debts remain the same. The debts incurred were mainly to cover essential household needs. It can be implied that the return to the full food ration value in August 2024 may have contributed to the reduction in debt. However, the situation still reflects the financial vulnerability of households, where debt could exacerbate the Rohingyas' poverty and precarity unless income opportunities are improved.

Livelihood support

Around 15% of households have been able to access livelihood skills training in the camps, such as non-formal technical training (51%), competency based/vocational training (47%) and other types of training (3%). Out of those who have attended training, 36% expressed being able to engage in income-generation activities as a result of the training. This coincides with Livelihoods and Skills Development Sectors' monitoring data from 2024, which indicates that of the 9,246 individuals trained, 30% were able to avail of different income sources (e.g. volunteering, running small businesses, trade) using skills acquired in the trainings. While women (18-59 years old) comprised the highest number of individuals trained at 60%, only 8% of them managed to engage in some form of income generating activity.[27] The same gender gap in income and livelihood opportunities points to the need for more robust, gender-sensitive livelihood interventions that go beyond skills training. While it is important to give equal opportunities to both men and women, it is also necessary to ensure that women have access to stable, sustainable income-generating opportunities. Targeted interventions, including market linkages, access to finance, and support for female entrepreneurship, and community engagement to encourage behavior change, are crucial to addressing the barriers women face in entering and sustaining participation in the workforce. Prioritizing these measures will be essential to not only enhance women's economic participation but also to contribute to overall household resilience.

Chart 3: Rohingya HH members who have accessed different types of skills training

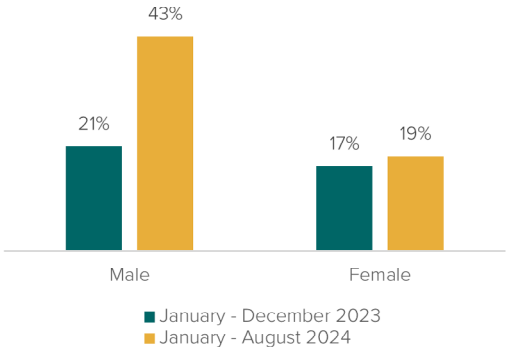


27. Cox's Bazar, Bangladesh. Livelihoods and Skills Development Sector.

Recommendations

- Advocate for favorable government policies such as 1) allocate market areas; 2) approve small businesses, 3) access to established supply chains for the movement of goods and commodities, 4) enable the private sector investment inside and outside the camps and 5) introduction of sim card registration along mobile wallet system.
- Prioritize women and youth in tailored, gender sensitive vocational, literacy and skills training that will also address specific socio-cultural barriers to participation such as safety concerns, childcare responsibilities, and gender norms.
- Promote multiple income streams by supporting micro, small and medium enterprises and market linkages among refugees and host communities.
- Enhance post-training support to ensure skills translate to income.
- Build economic resilience through job-creation and entrepreneurship.
- Develop market-oriented training programs based on demand assessments.

Graph 22: Enrolment in skills training by gender (total enrollees – 9,246)



NUTRITION

The deteriorating nutrition situation is an interplay of different factors associated with food security, nutrition, livelihood, health, and social protection.

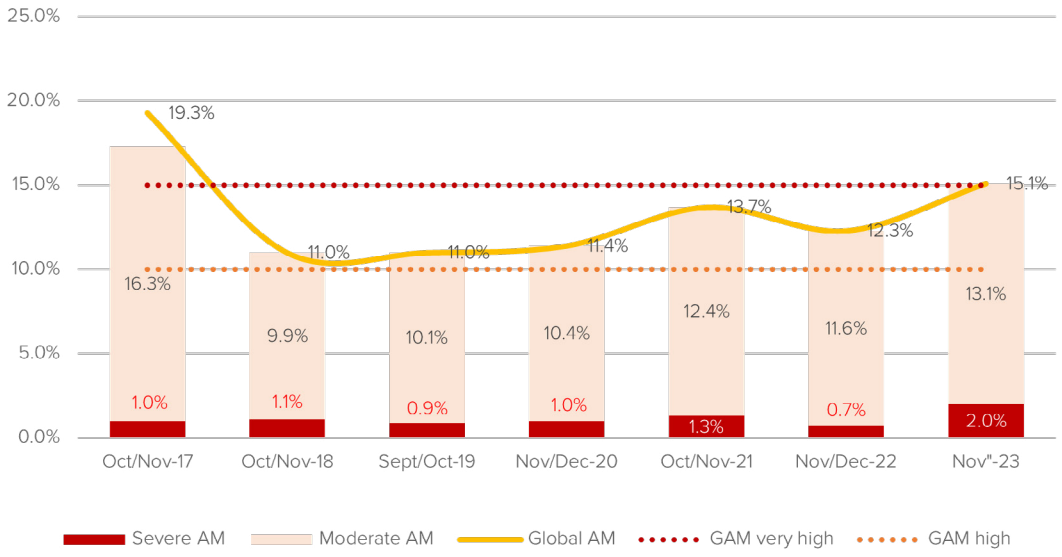
Data referenced in the analysis for Nutrition Sector comes from the Standard Expanded Nutrition Survey 2023 and more recent and relevant data.

Malnutrition

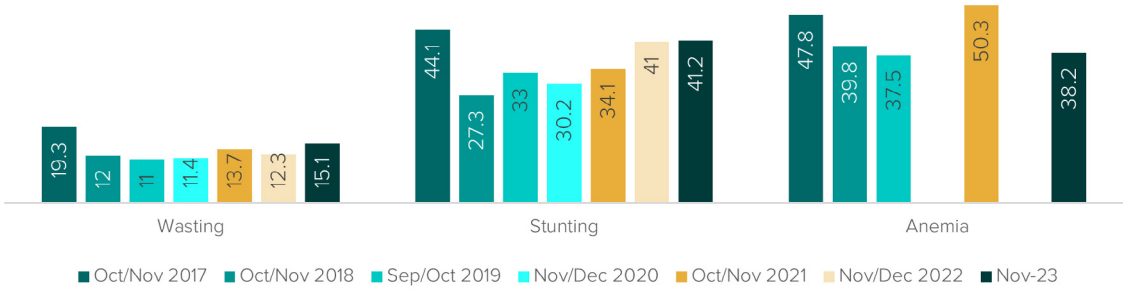
The Standardized Expanded Nutrition Survey (SENS) 2023 revealed a worsening malnutrition situation for children per Graph 23. The critical prevalence level for wasting among children 6-59 months increased from 12.3% in 2022 to 15.1% in 2023. Severe wasting nearly tripled from 0.7% in 2022 to 2.0% in 2023.[28] This is evidenced in the increase in admissions from January-August 2024 by 20% (6,195 to 7,441) and moderate wasting by 40% (24,100 to 32,779) compared to the same period in 2023.[29]

Chronic malnutrition (stunting) remained critical and essentially unchanged compared to 2022 (41%), which is classified as very high according to WHO/UNICEF classification systems. Stunting trends are concerning, with a high proportion of refugee children showing signs of stunting from 6-8 months of age. Stunting prevalence then increases with age, peaking at 53% among children aged 24-35 months before declining slightly by 48-59 months. Anemia prevalence (38%) though in decline, remained high among children in the 2023 SENS and at a medium level (24%) among women of reproductive age.[30]

Graph 23: Trend of Global, Moderate and Severe Acute Malnutrition (6-59m) (2017 - 2023)



Graph 24: Trend of admissions among 6-59 months in 2023 and 2024



28. UNHCR (2023). Standard Expanded Nutrition Survey (SENS). (version updated January 2024)
29. Cox's Bazar, Bangladesh Nutrition Sector, 2024.
30. Ibid.

Food insecurity

The deteriorating nutrition situation in 2023 evidenced the interplay of food, health, WASH and social protection systems. The food ration cuts may have contributed to this situation, with an initial reduction from USD 12 to USD 10 in March 2023, to USD 8 in June 2023, before climbing slowly back up to the full ration in 2024.[31]

On infant and young child feeding (IYCF), 70% of children under 6 months are exclusively breastfed, which is an improvement compared to 62% in 2022. For the 30% who did not exclusively breastfeed, non-breastmilk liquids were introduced in the first two days including sweetened tea, cocoa, and water mixed with honey/sugar/glucose. The main reasons for introducing non-breastmilk liquids were family, cultural, social, and religious beliefs and practices. Continued breastfeeding for the first two years occurred at acceptable levels, but complementary feeding practices were sub-optimal.[32]

The 2023 SENS also shows that only 27% of children aged 6-23 months consume food from less than five of the recommended eight food groups meaning children's diets are not diverse enough to meet their nutritional needs. There has been a decline in the following: minimum dietary diversity (28% to 27%), meal frequency (69% to 47%), and the minimum acceptable diet (23% to 17%) from 2022 to 2023.[33,34]

Diarrhea

The two-week prevalence of diarrhea among children aged 6-59 months rose from 9.5% in 2022 to 22.0% in 2023, with a higher incidence (31.5%) noted in younger children 6-23 months. Furthermore, diarrhea was more prevalent among wasted children (28%) compared to non-wasted children (18%). Troublingly, only 30% of children under 5 were reported as using a latrine/toilet, while 68% were defecating in open space[35] which may increase the prevalence of acute watery diarrhea.

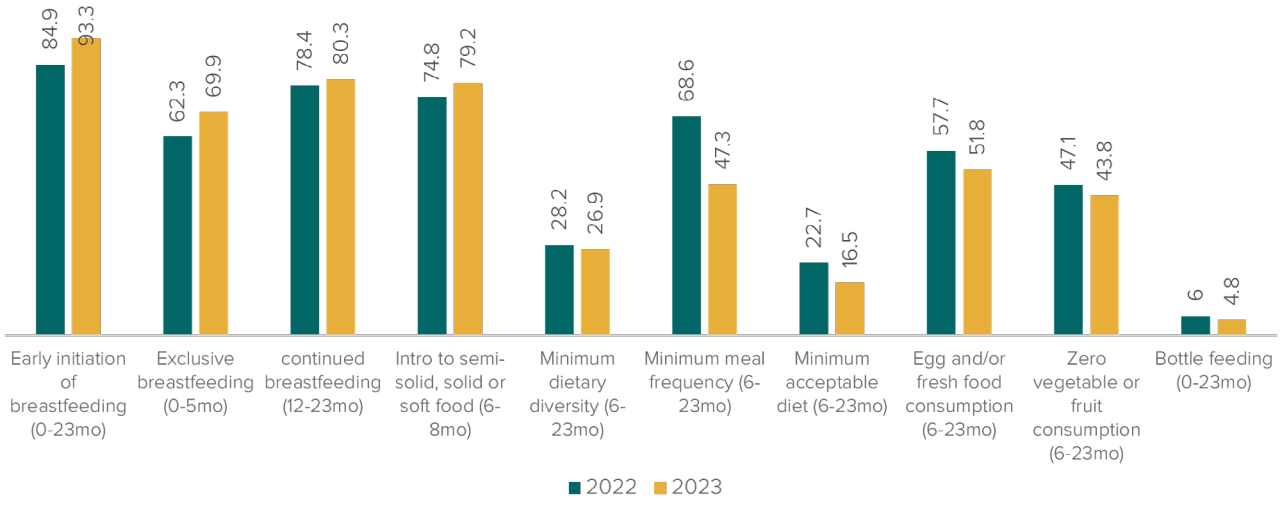
Coping mechanisms

The REVA 7 also indicated that Rohingya households were struggling to secure sufficient food at end-2023 and were frequently resorting to negative coping strategies to meet their food needs. About two-thirds of households (67%) relied on less preferred or less expensive food as their most frequently used coping strategy.[36] This would directly impact the quantity and quality of food intake among children and pregnant and breastfeeding mothers.

Other vulnerabilities[37]

A negative nutrition situation among children is likely to cause notable growth, developmental and health consequences if left unaddressed. For instance, children with severe wasting are eleven times more likely to die than non-wasted children, stunted children have 5.2 times

Graph 25: IYCF prevalence trends among Rohingya children 0-23 months (2022-2023)



31. Cox's Bazar, Bangladesh Nutrition Sector (2024, September). Ration Cut Impact on Nutrition: Monitoring Update (Round 1 & 2) 2023. The Impact of General Food Assistance Ration Cuts on Nutrition - Monitoring Update (Round 2) September 2023 - Bangladesh.
32. Cox's Bazar, Bangladesh Nutrition Sector (2022, July). Infant and Young Child Feeding Practices, Rohingya Camp, Cox's Bazar, July 2022 <-- indicate only 1x in all ISCG web citations.. Also does July 2022 bear repeating?
33. Ibid.
34. UNHCR (2023). Standard Expanded Nutrition Survey (SENS). (version updated January 2024).
35. Ibid.
36. WFP (2024, July). Bangladesh Refugee Influx Emergency Assessment (REVA- 7).
37. Black RE, Victora CG, Walker SP, Bhutta ZA, Christian P, de Onis M, Ezzati M, Grantham-McGregor S, Katz J, Martorell R, Uauy R; Maternal and Child Nutrition Study Group. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet. 2013 Aug 3;382(9890):427-451. doi: 10.1016/S0140-6736(13)60937-X. Epub 2013 Jun 6. Erratum in: Lancet. 2013. 2013 Aug 3;382(9890):396. PMID: 23746772.

lower average IQ than non-stunted children, and 35% of the overall disease burden in children under 5 is due to malnutrition and maternal short stature. For expectant mothers, iron deficiency anemia increases the risk of death by at least 20%.

Children's poor nutrition can also be attributed to poor and deteriorating diets centered on the high consumption of cheap sources of calories, low dietary diversity, and less nutrient-rich foods. Secondly, there are increasing trends in diarrhea cases in younger children due to compromised water and sanitation, and health service gaps including for vaccination and di treatment. Thirdly, limited access to income and livelihood opportunities aggravates household food insecurity. Child marriage also perpetuates the cycle, with very young mothers unaware of and/or unable to provide proper childcare and feeding practices.

The Nutrition Sector provides services to all vulnerable target groups, including children, adolescents, and pregnant and breastfeeding women. However, the conditions in the camps and challenges faced by Rohingya households (i.e. access to healthcare and medicines, food insecurity, psychological distress, poor and insecure living conditions, environmental hazards) easily push children into a spiraling cycle of disease and malnutrition. Additionally, there is a gap in nutrition services for the elderly, who have not been prioritized due to a lack of funding.

Recommendations

- Tailor WHO's 2023 wasting management and prevention guidelines to the local context and ensure adoption and endorsement for effective implementation.
- Focus more strongly on collaboration and multi-sector programming to promote nutrition-sensitive interventions (e.g. with the Health, Food Security, and WASH sectors, and GBV sub-sector).
- Evaluate the effectiveness of locally produced ready to use therapeutic food being piloted in the camps for the treatment of malnutrition.
- Integrate nutrition programmes with food fortification, income-generating activities, and vegetable garden initiatives to improve dietary diversity, household food security, and overall nutrition security.
- Support a point-of-care approach which delivers high-quality IYCF counseling through health service providers, including community workers.
- Conduct a nutrition causal analysis and adopt a multisectoral approach in response to address its findings.
- Streamline cross-cutting issues across all nutrition services.
- Enhance digitalization of record keeping and reporting systems to strengthen information management and evidence generation.
- Implement adolescent-specific comprehensive health programmes aiming at engaging adolescents to address the significant malnutrition burden they face.

EDUCATION

Despite the high enrolment rate of Rohingya children 5-12 years old, there is sharp decline of school attendance from ages 13-18, which is disproportionately higher among girls.

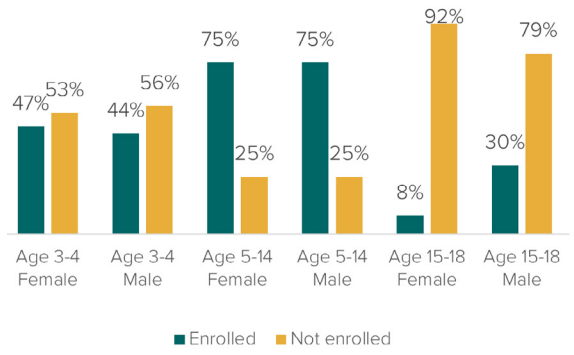
Households accessing education services

The 2024 ISNA, revealed 78% of Rohingya households with children aged 3-18 had them enrolled in learning facilities. However, the remainder (22%) of households were unable to send any of their children to learning facilities.

Children accessing education services

According to the Education Sector's 5W data, 24% of school-aged children were not enrolled in learning facilities by end September 2024.[38] However, according to the ISNA, a higher proportion (41%) of school-aged children were not in school due to dropouts, children unable or facing difficulty to attend school and child protection related issues.

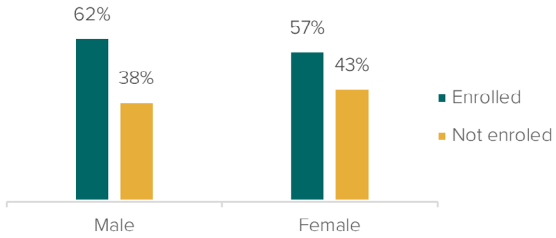
Graph 26: Status of enrolment of Rohingya children by age and gender (2024)



38. Cox's Bazar, Bangladesh, Education Sector (2024).

Analysis of the enrolment trends show a higher number of children enrolled from ages 3-7, but numbers start to consistently drop from ages 8-18. In 2024, the highest enrolment is seen among children 5-7 years old, which is between 83% and 92% respectively. There is a sharp decline in enrollment among 13–18-year-olds with as much as 75% of children out of school from 16 years and up. This gap is even more pronounced for girls 15-18. However, the majority (96%) of learners were attending classes consistently at least 4 days a week which is within Sector standards (the remaining 4% are considered irregular students) (see graph 28).

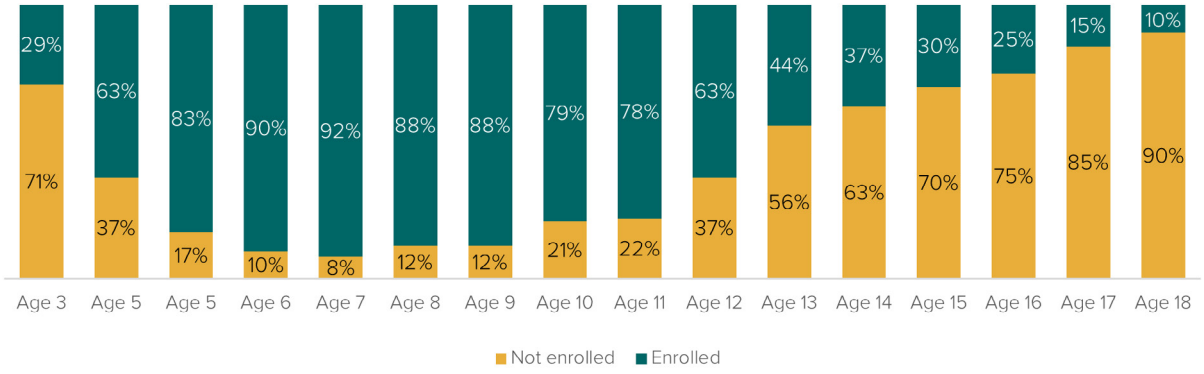
Graph 27: Overall status of enrolment of Rohingya children in 2024



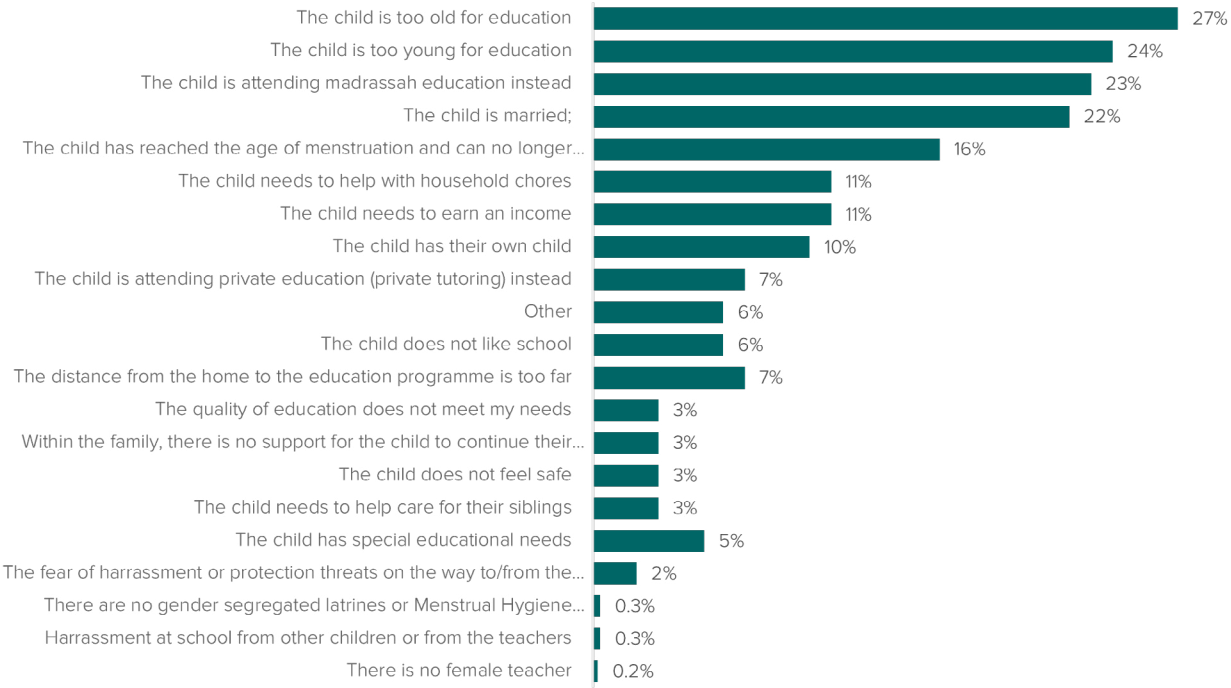
Households who have children with non-regular attendance and/or children unable to enroll cited several reasons for non-participation (see graph 29).

Insecurity in the camps was a contributing factor for non-attendance, given household fears of children being abducted (54%), of criminal groups (36%), and of forcible recruitment (5.2%). Other safety threats raised included inundation of access roads to learning centers (21%), harassment of girls (5%), and barriers for children with disabilities and mobility issues (2%). Child protection cases (such as child marriage, child labor, child neglect, physical violence against children, child trafficking and recruitment to criminal groups for adolescent boys) are similarly cited as risks in child protection monitoring – and significantly

Graph 28: Proportion of children 3-18 years enrolled in camp learning facilities (2024)



Graph 29: Reasons for children unable to enroll or attend classes in learning facilities



contribute to feelings of children not being safe within and outside the household. Forty-four percent (44%) of Rohingya households expressed that children are not interested to attend learning facilities, which requires further investigation into the causes of disinterest among children. However, Rohingya households recommended several ways to encourage children to enroll in education, as presented in graph 30.

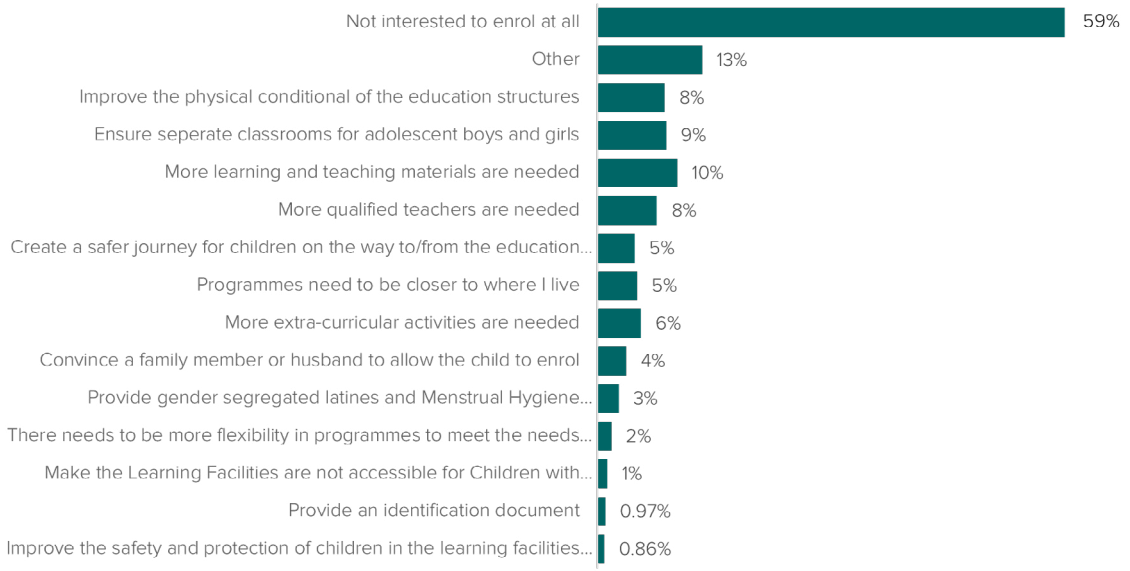
Learning facilities

In the camps, there are 5,994 learning facilities, each serving an average 80 learners in two shifts (40 in the morning and 40 in the afternoon) with a smaller number of learners (30) in informal community-based learning facilities (CBLF).[39] Most children are enrolled in learning centres (81%), with the remainder attending CBLF (14%), multi-purpose centres (4%) and mixed-use spaces (1%).

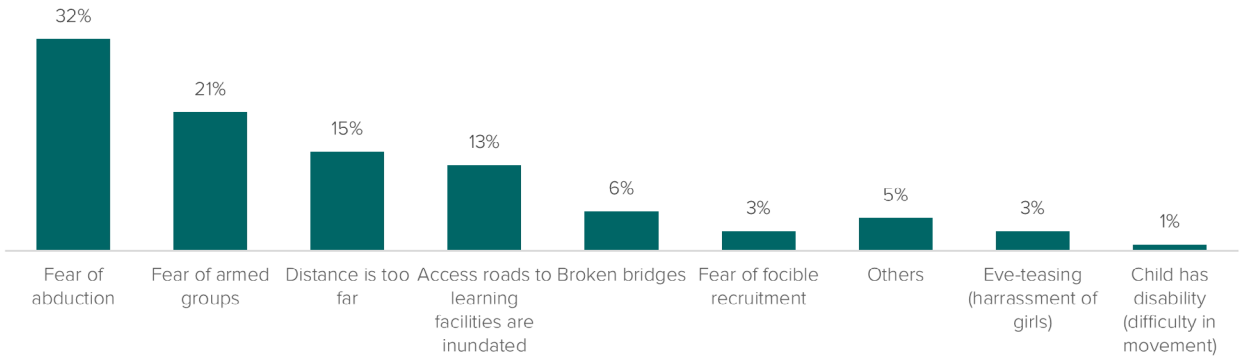
Recommendations

- Advocate for weather resilient and more durable learning facilities, including the use of double-story buildings to alleviate the shortage of learning spaces.
- Increase enrolment and retention of learners to reduce non-enrolment and non-attendance rates.
- Increase access to alternative learning pathways and modalities for adolescent girls, especially at the secondary level, to increase enrolment and retention.
- Continue and increase teacher professional development to enhance the quality of teaching and learning.
- Provide pathways for the continuation of education beyond secondary school level (i.e. tertiary education, other technical training institutes).
- Advocate for recognition of learning for Rohingya children through accreditation or certification.

Graph 30: Recommendations to encourage children to enroll



Graph 31: Safety threats for Rohingya children travelling to and from the learning facilities



39. Cox's Bazar, Bangladesh, Education Sector (2024).

HEALTH

Rohingya households continue to face the risks of exposure to communicable and non-communicable diseases and access to healthcare services is not sufficiently equitable.

Data and analysis referenced below comes from the Public Health Needs Assessment 2024-2025 only (sample size of 670 households) unless otherwise cited otherwise. Results are representative overall but camp disaggregation is not available.

Priority services

In the 2024 - 2025 Public Health Needs Assessment (PHNA),[40] the top priorities for health were to continue 1) providing services, including strengthening primary health care, and 2) non-communicable disease (NCD) management, immunization, and surveillance, emergency preparedness and response, community health services, and provision of medicine and medical supplies and equipment. A third priority identified was health system strengthening (including referral services, health information system, infection prevention and control, and WASH in health facilities.

Health status

The health status of the Rohingya refugee population is characterized by a high burden of communicable and non-communicable diseases, reflecting systemic challenges and persistent vulnerabilities to health. Hepatitis C affects 19% of adults, with over 100,000 individuals requiring urgent treatment. Meanwhile, chronic diseases such as hypertension and diabetes are prevalent in 33% of households, disproportionately impacting PWD.

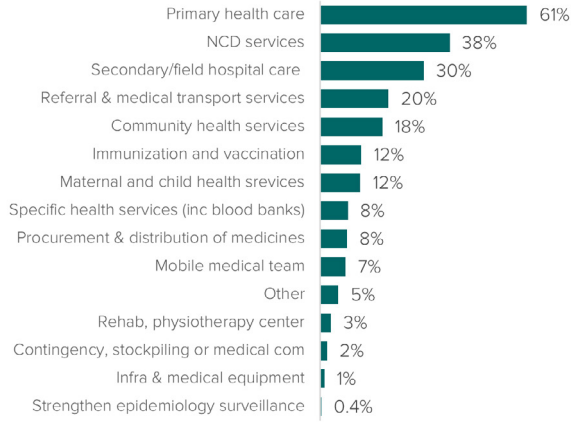
Access to healthcare services is not sufficiently equitable. While 93% of respondents reported utilizing NGO-operated facilities that provide free medical care, 22% experienced barriers to accessing care due to the unavailability of required services, transportation challenges, or long waiting times. The top five public health concerns identified by refugees were acute respiratory infection, followed by acute watery diarrhea, skin diseases, gastrointestinal problems, hypertension, and Hepatitis B & C.

Access to health care

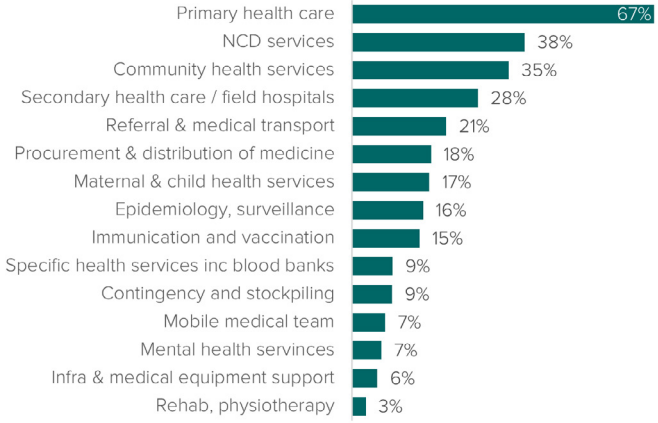
Access to healthcare services is constrained by systemic barriers, with 22% of household respondents reporting difficulties in obtaining care due to the unavailability of requisite services, transportation challenges, and long wait times. While 93% of individuals utilize free medical care from NGO-operated facilities, significant gaps in service coverage remain, particularly for specialized care. Facility-based delivery rates for maternal health are below 50% with an ongoing reliance on home births among pregnant women, and emergency referral systems are often hampered by inadequate transport and communication. Addressing these challenges requires targeted investments in service expansion, improved referral pathways, and community engagement to promote formal healthcare utilization.

Vulnerable groups, including under 5 children, pregnant and breastfeeding women, the elderly, and PWD, are disproportionately affected by systemic gaps in healthcare delivery. Under 5 children represent 47% of cholera cases, highlighting their vulnerability to waterborne diseases. Pregnant women face barriers to accessing antenatal care and facility-based deliveries, while the elderly and PWD often encounter limited-service availability and accessibility challenges.

Graph 32: Most urgent health services



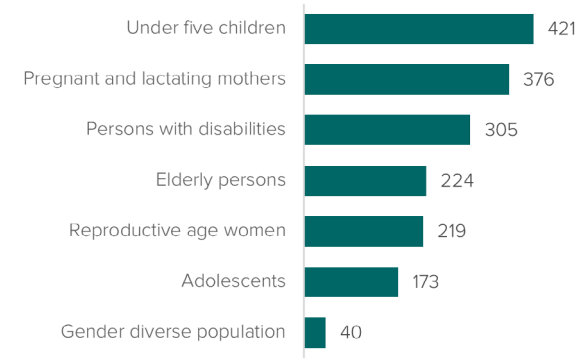
Graph 33: Top 5 priority interventions for the Health Sector (medical workers & NGOs)



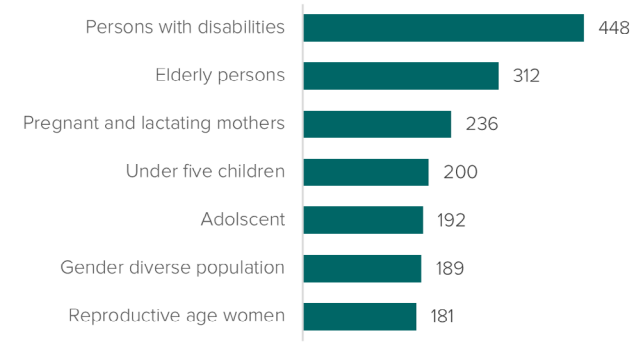
Note: The graphs above show the priority needs of Rohingya HHs by by rank. Ranks are generated using the following scoring system: rank 1 (5 points), rank 2 (4points), rank 3 (3 points), rank 4 (2 points), rank 5 (1point).

40. Cox's Bazar, Bangladesh Health Sector (2024). Public Health Needs Assessment (PHNA) in Rohingya Refugee Camps 2024-2025. PHNA 2024-2025.

Graph 34: Most vulnerable groups among Rohingya refugees



Graph 35: Most vulnerable groups with the least access and most difficulties accessing health services



Access to medicines

Medicine shortages continue to undermine healthcare delivery, with 23% of facilities experiencing regular stockouts of essential drugs. These shortages disproportionately affect medications for non-communicable diseases, pediatrics, hepatitis, and mental health. Consequently, 32% of households also rely on private pharmacies, and [13]% turn to illegal drug dispensers, where quality and safety are unregulated. Bridging these gaps requires improved supply chain management, strategic procurement, and donor support to ensure consistent access to essential medicines.

Persons with disabilities

PWD face significant barriers to healthcare, with 29% of households with PWD reporting challenges in accessing services. This includes physical accessibility issues, lack of tailored services, and the stigma associated with disability. Fifty two percent of PWD lack access to essential mental health and psychosocial support. In addition, PWD are more likely to develop chronic health conditions, including diabetes mellitus and hypertension.

Maternal and child health

Maternal and child health outcomes remain a significant concern, with maternal mortality rates exceeding global thresholds and reported facility-based deliveries below 50%. Access to antenatal care is uneven, and reliance on traditional birth attendants persists, due to cultural norms and misinformation. Inadequate referral systems further delay access to emergency obstetric and neonatal care. Strengthening healthcare delivery for maternal and child health requires investments in facility-based services, referral pathways, and community education to promote the use of skilled care.

Mental health and psychological support

Mental health challenges are widespread in the camps, with 32% of households reporting emotional distress or trauma. However, only 39% of people in need actually access mental health or psychosocial support services, a figure which rises slightly to 48% among PWD. Stigma, limited availability of mental health professionals, and lack of integration of mental health services into primary healthcare contribute to these gaps. Expanding mental health services, training healthcare workers, and promoting community-based psychosocial support are critical to addressing this pressing need.

Chart 4: Rohingya HHs with members who have experienced emotional distress or trauma in the past 6 months

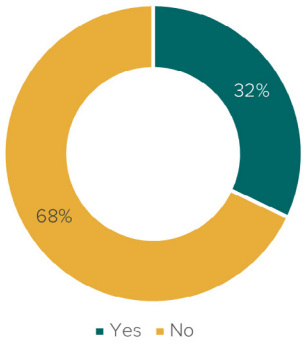
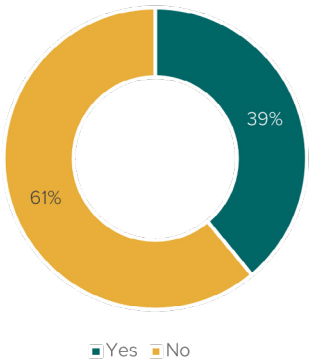


Chart 5: Rohingya HHs with members who have received any pychological or mental health support



WASH in health facilities and infection prevention and control

WASH infrastructure in health facilities remains inadequate, with 41% of facilities lacking proper sanitation, 33% failing to meet waste management standards, and 17% relying on water sources located more than 500 metres away. These deficiencies contribute to the spread of waterborne

diseases like cholera and diarrhea and undermine infection prevention and control measures.

While current health services reached and provided services to almost all Rohingya households, strengthening the health system is critical. For instance, WASH infrastructure in the health facilities needs to be further improved to meet standards and maintain good health. In addition, health information systems (HIS) need to be enhanced, as of report services were still transitioning from multiple health cards to a digital e-system for data collection, which will enhance system efficiency, contribute to evidence-based planning and help to monitor progress). Referral services emerged as a priority, specifically the need to revisit referral guidelines and standard operating procedures.

Recommendations

- Sustain and support primary and secondary health care, including NCD management, mental health, maternal and child health, and communicable diseases, with a focus on quality and strengthening community-based health approaches.
- Expand health services, such as immunization, surveillance and information management, and outbreak emergency preparedness and response.
- Strengthen health systems, including referral services, the transition to a unified, digital HIS, and WASH in health facilities.
- Improve access to health services for PWD and the elderly.

PROTECTION

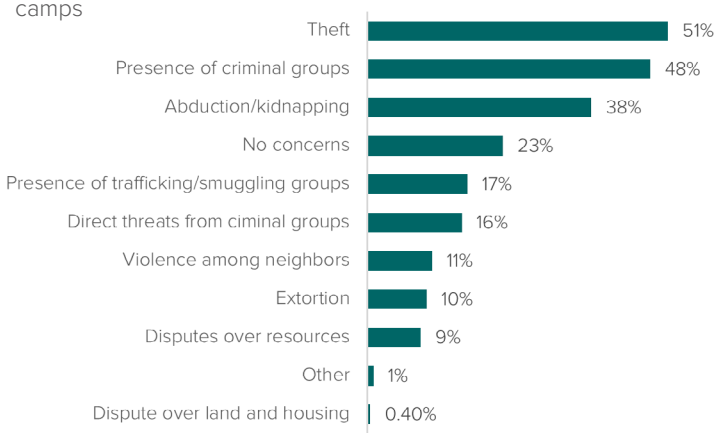
Safety and security remain the most pressing concern for Rohingya refugees due to escalating violence and activities of organized criminal groups that caused distress and disrupted daily activities.

Below data comes from multiple sources including ISNA 2024, Joint Protection Monitoring, Child Protection Monitoring System, and GBV Information Management System. Data mainly come from ISNA unless otherwise referenced.

Safety and security

Between April and September 2024, the main security risks identified by Rohingya households were theft (50%), the presence of criminal groups causing fear of gunshots and confrontations (48%), and abduction and kidnapping (38%). Other security threats include direct threats from criminal groups (17%), trafficking (17%), violence among neighbors (11%), disputes over resources (9%) and extortion (10%) (see graph 36). Overall, 59% of Rohingya households reported feeling unsafe due to these security issues. There were 157 reported incidents of abduction and kidnapping (including 31 boys and 5 girls) arising mainly due to the forcible recruitment of adolescent boys and adult males to fight in Myanmar and other cases where criminal groups demanded ransom.[41]

Graph 36: Security risks identified by Rohingya HHs in the camps



Protection risks

Crime and violence were perceived as the main protection risks among 61% of refugee households. Psychological distress was reported by 33% of refugee households and of these households at least one member has shown symptoms. This increase highlights the link between compromised security situations and the likelihood of developing mental health symptoms that may progress to illness requiring specialized long-term interventions and treatments. Security, being a critical social determinant of health, can affect the likelihood of developing new symptoms, exacerbate existing disease, as well as jeopardize the accessibility of care, thus impacting population health and individuals' ability to function in day-to-day life.

Access to services

Some refugees indicated an increasing difficulty in accessing essential services such as food, water, healthcare, and education due to increased insecurity, distance from service centers, and lack of adequate transportation. Eleven percent of households mentioned concerns about disputes amongst neighbors due to conflict over shared facilities (e.g. WASH, shelter space, pathways, stairs (see table 4), while 10% of households highlighted extortion as a significant issue, with organized groups demanding money or goods (see graph 36).

Mental health and psychological distress

Approximately one third of households reported having at least one member with symptoms of psychological

41. Cox's Bazar, Bangladesh Protection Sector (2024, September). Joint Protection Monitoring Report Q3.

distress. This finding is consistent with the MSNA 2023 which showed a slightly higher figure (38%). The highest number of distressed households were reported in Camp 4E (82%), Camp 12 (52%), and Camp 2E (51%).

Security, being a critical social determinant of Public Health, can impact the likelihood to develop new symptoms, exacerbate previously existing diseases, as well as wider accessibility to care and thus impacting the population's health and ability to function. Among the reported symptoms of psychological distress, the most common were excessive worry and feeling unsafe (66%) and difficulty sleeping (53%), with other less common symptoms outlined in graph 39.

Housing and land property (HLP)

There is an overlap between Rohingya settlements and host communities with established rights under social forestry agreements in Teknaf and Ukhiya. This has steadily caused a large caseload of property rights issues, such as land claims, rental charges, and evictions.[42] With 50,000 new arrivals from Myanmar entering the camps in 2024, as well as significant political shifts in Bangladesh, a fresh wave of HLP issues emerged in 2024. In various camps, host community members began asserting ownership of land and demanding rent from refugees who had previously sheltered there without issues. Some refugees have faced eviction as professed landowners have sought to charge higher rent to new arrivals. In other cases, Rohingya refugees have been asked to pay increased rent simply because they are hosting relatives from among the new arrivals.

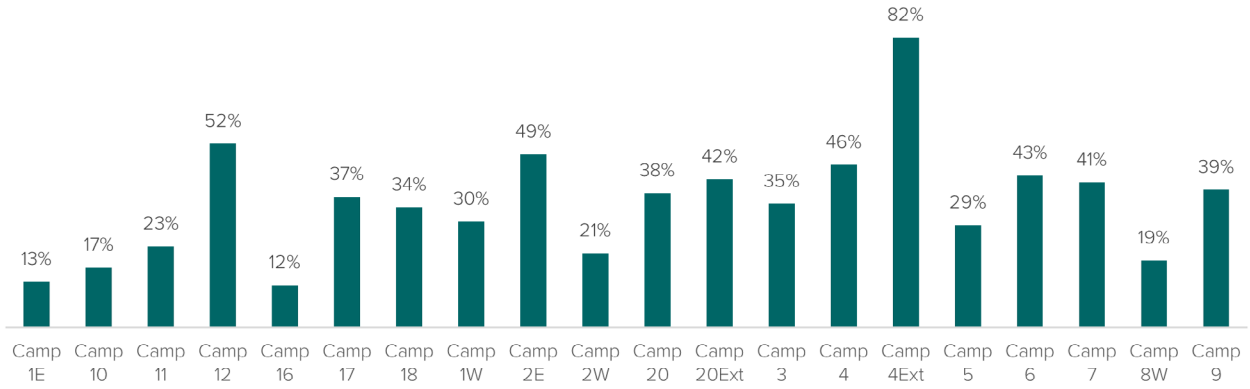
Eighty-nine percent (89%) of refugee households reported lacking any written proof or document for the shelter/land they occupy, making them highly vulnerable to eviction and exploitation. According to national law, refugees cannot obtain land ownership papers but can draw up rental agreements and obtain customary tenure security documentation. Only 8% of respondents have a clear verbal agreement with landowners (whether renting or occupying the land for free) and barely any (1%) perceive that they own the land they occupy.

The increasing number of disputes between refugees and host communities, particularly over land and property rights, poses a significant challenge for Rohingya refugees as they do not have the proper documentation to support their temporary settlement. An increase in instances where host communities claiming ownership of land designated

Graph 37: The most serious protection risks identified by Rohingya HHs in the camps

*Others combined: risks of physical injury caused by disasters, disputes between Rohingya and the host community, problems created by lack of services, property disputes, and eviction from shelters.

Graph 38: Rohingya HH with members who experienced pschological distressed in the past 6 months



42. Cox's Bazar, Bangladesh Protection Sector (2024). Factsheet: Rohingya Housing, Land and Property Issues in Cox's Bazar, Bangladesh January- August 2024. Document unpublished- please reach out to the Sector.

as public has been recorded. From January-August 2024, 4,599 HLP related cases were registered of which 17% are related to eviction (a 4% increase compared to 2023) and 50% were complaints from women.[43] Table 4 indicates the number and most common types of HLP cases recorded in the camps.

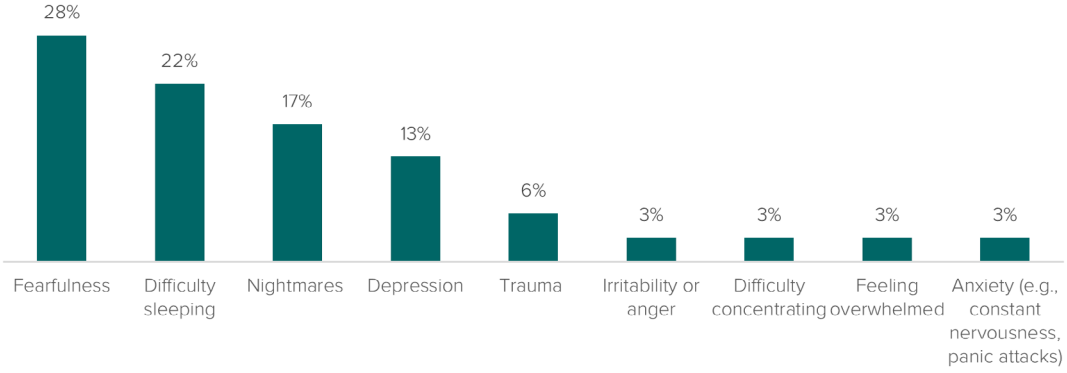
Table 4: Type of HLP cases registered (January-August 2024)

Types	# of cases	% of cases
Dispute over access to facilities and services (including access to shelter/pathways, access to public facilities/annexation of facilities, encroachment, boundary disputes)	1,606	35%
Forced evictions (including eviction threats)	771	17%
Rental disputes (including rental increases and arbitrary rent of public land)	646	14%
Dispute over transfer of shelter ownership (including conflict due to lack of diligence or use of right, inheritance dispute (host community), dispute over shelter transactions)	387	8%
Other disputes (including relocation)	1,189	26%

Recommendations

- Strengthen protection and security measures by increasing patrolling and the presence of law enforcement agencies within the camps and along high-risk zones, to deter organized criminal activities and ensure safety for vulnerable groups, especially youth.
- Expand community-based protection mechanisms by supporting and scaling up community-led protection initiatives, such as safety watch groups and awareness programs, to promote collective action against violence and intimidation.
- Advocate for registration and basic assistance. Engage with relevant authorities to prioritize registration of new arrivals to ensure access to essential services and reduce strain on other refugee households.
- Strengthen humanitarian assistance by providing targeted support to families hosting new arrivals through additional food rations, shelter materials, and other resources, particularly in Teknaf where rent pressures exacerbate vulnerabilities.
- Advocate for accessible and expedited formal legal processes to reduce dependence on traditional justice systems, while also building the capacity of community leaders to ensure neutrality, confidentiality, and ethical practices in dispute resolution.
- Establish satellite service delivery points or mobile units to bring essential services (e.g. healthcare, education, food distribution) closer to camp residents, particularly in areas with limited transportation access.
- Improve infrastructure and safety around service centres.
- Advocate for more livelihood and skill development opportunities to prevent and address harmful coping mechanisms and other protection concerns, and to empower communities, particularly young people.
- Develop and implement a comprehensive mental health response strategy that prioritizes the integration of mental health and psychosocial support (MHPSS) services with security improvements in high-prevalence camps.
- Implement community engagement programmes to foster trust and mutual understanding between refugees and host communities. Enhance monitoring of housing, land, and property issues, and develop targeted interventions that provide legal and technical support for equitable resolutions.

Graph 39: Common symptoms and signs of psychological distress experienced by refugees



43. Cox's Bazar, Bangladesh Protection Sector (2024). Factsheet: Rohingya Housing, Land and Property Issues in Cox's Bazar, Bangladesh January- August 2024. Document unpublished- please reach out to the Sector.

PROTECTION - CHILD PROTECTION

Child recruitment

Children are highly exposed to, and experiencing, serious protection risks and threats in the camps. Reports during the year included the abduction, recruitment, and use of children by those carrying arms, as well as the killing and injury of children and other serious violations.[44] Some children were reportedly taken for military training and then onward to Rakhine State in Myanmar as child soldiers. Focus group discussions with the community indicate that the methods used to recruit children often involve community meetings, promises of financial incentives, and enticement to receive one-time payments if they join the fight in Myanmar. Criminal groups may also coerce children through threats and force them to commit crimes. They also use children for labour, drug trafficking, and as informants.

Child marriage

Another significant protection concern is child marriage, with 64% of key informants interviewed in the camps reporting this practice within Rohingya communities.[46] In 2024, 5% of children were reportedly married underage as a result of cultural norms (19%), poverty (18%), romantic relationships (17%), social insecurity (13%), lack of adequate shelter space (11%), food insecurity (7%), the pursuit of better security (7%) and forced marriages involving members of criminal groups (5%).[45]

Child labor

The struggle to meet daily household needs also forced children to engage in labor or income-generating activities, thus preventing them from enrolling or completing education in learning facilities. For the monitoring period January to September 2024, 65% of the Sub-Sector's key informants reported known child labor cases, of which 37% said the children had become the head of their household. Half of those interviewed shared that even children with specific needs are forced to engaged in labor.[46]

Children outside of their homes

About 17% of Rohingya households report having children who have left their homes to seek employment, 17% who have gotten married, 5% who are missing (left and no news since), 4% who have been kidnapped or abducted, and 1% who have been detained, which underscores the severe security risks children are exposed to in the camps.

Children outside of their homes

At least 87% of Rohingya households reported having access to child protection services. Non-access among the remaining 13% of respondents was attributed to distance from the services centers (28%), fear of abduction (24%), lack of awareness (22%), and inadequate service provision (5%), as well as stigma/discrimination, financial constraints, lack of trust, and cultural or social barriers.

Table 5: Top types of labour conducted by Rohingya boys and girls under 18 years old.

Boys	% of key informants	Girls	% of key informants
Working in mines	15%	Domestic work	26%
Carrying loads	15%	Sewing, tailoring, handicraft	21%
Day labor	13%	Agriculture	9%
Driving tom-tom	10%	Working in markets	6%
Agriculture	8.5%	Day labor	5%

Note: For a complete list, please reach to CPSS focal point.

Recommendations

- Bolster the security presence and remove arms from the camps to protect children from recruitment, trafficking, and abductions.
- Establish mechanisms to improve Rohingya children's access to justice, ensuring legal frameworks protect them from exploitation, trafficking, and abuse.
- Promote and expand livelihood programmes within the camps to reduce reliance on child marriage, child recruitment, and child labour, and enable children to attend school.
- Expand and enhance mental health and psychosocial support services for children and caregivers to address psychological distress and improve children's well-being.
- Invest in continuous training for specialized child protection workers to respond effectively to complex issues.
- Develop policies and strategies promoting access to education for vulnerable children, including those involved in labour, children with disabilities, and girls facing cultural barriers.
- Expand government enforcement of laws against

44. Cox's Bazar, Bangladesh Protection Sector (2024, September). Joint Protection Monitoring Report Q3.
45. Child Protection Sub-Sector Cox's Bazar (2024). Child Protection Situation Monitoring, 2024. Data is not published, reach out to Child Protection Sub-sector for details.
46. Ibid.

child labour, ensuring penalties for those exploiting children.

- Lead community-based child protection awareness campaigns addressing child labour, recruitment, and child marriage, involving key community figures like Majhis and religious leaders.
- Integrate child protection services with other Sectors, mainly Health and Education, to enhance service accessibility and reduce stigmatization.
- Create safe spaces for adolescent girls, ensuring access to education, recreational activities, and psychosocial support without fear of harassment or movement restrictions.

PROTECTION - GENDER BASED VIOLENCE

GBV risks associated with food insecurity

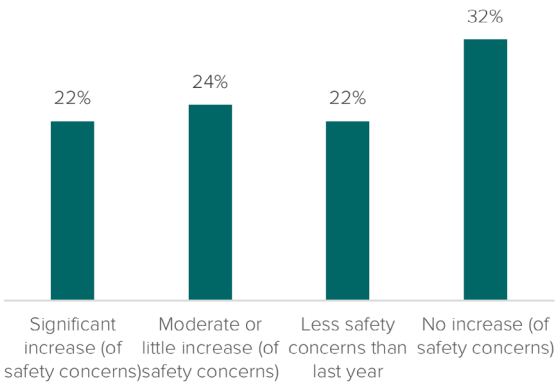
Food insecurity is identified as a major contributing factor for all types of GBV. Nearly three-quarters 73% of households (19% female-headed, 54% male-headed) reported that they bought food on credit or with money borrowed from relatives and friends. Fourteen percent (4% female-headed, 10% male-headed) reported reducing their expenditure on health, feminine hygiene products, and education, to meet basic needs, as well as selling household items.

Reduced food rations and limited access to livelihood opportunities increased stress levels and contributed to gender-based violence. Sub-sector data indicated that GBV perpetrators were typically unemployed (41%) and most were intimate partners of the survivors (76%).[47] The high rates of unemployed perpetrators suggests that men's loss of status as breadwinners and unfulfilled expectations around their traditional roles are linked to intimate partner violence in the camps. At the same time, limited access to livelihood opportunities has promoted harmful coping mechanisms such as drug abuse, and human trafficking.[48]

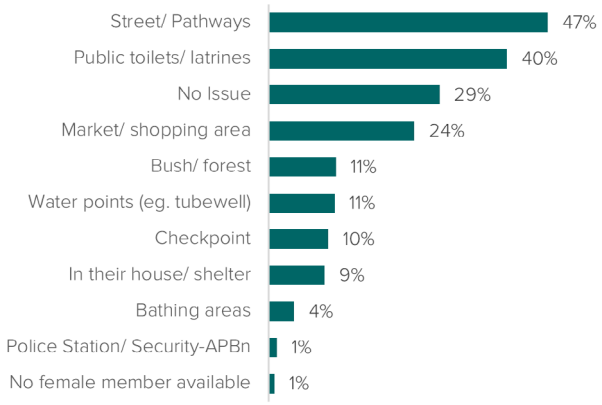
Safety in camps/sites

Nearly half of surveyed households perceived an increase in safety concerns over the past years. Interestingly, 46% of the Rohingya households reported there were greater safety concerns for women and girls, 52% for men and boys. Street/pathways (47%), public toilets/latrines (40%) and market / shopping areas (24%) were the locations considered most unsafe (both day and night) for women and girls, due mainly to the lack of lighting at night and the risk of being targeted by criminal groups.

Graph 40: Rohingya HHs who reported changes in the safety and security of women in the camps



Graph 41: Locations in the camps where women and girls feel unsafe (day and night)



Access to GBV services

Ninety-four percent (94%) of the household respondents were aware of the GBV services available nearby their shelters, and both Women Girls Safe Spaces (82%) and Women Friendly Spaces (44%) were identified as viable GBV service points. The majority (87%) of households reported that women and girls have access to specialized reproductive health services, with the remainder (13%) lacking access, which could be attributed to insecurity in the camps. Household respondents mentioned knowing that GBV services were available at WFS, WGSS, WLCC, MPWC, as well as Health or nutrition facilities with GBV case management services, integrated protection centers, community engagement centers, and multi-purpose community centers, and other assistance sites.

Women's specific risks and vulnerabilities

Nineteen percent (19%) of respondent households are female headed who bear the burden of ensuring that the

47. UNFPA (September 2024). GBVIMS Factsheet (Q3, 2024).
48. UNFPA (June, 20204). GBVIMS Factsheet (Q2, 2024).

family have met their basic and essential needs. Gender-related risks for women and girls include sexual assault and harassment, domestic violence, and exploitation. Domestic violence was reported in 5% of households with intimate partner violence as the most common form of violence. Women also cited the risk is heightened in public spaces, such as streets and pathways (47%), toilets (40%), markets (24%) and water points (6%). The exacerbating factors were noted to include lack of lighting at nighttime (84%), targeting by criminal groups (66%), and the risk of sexual assault (18%) in public spaces.

Rohingya women and girls continue to face numerous overlapping vulnerabilities in the camps. Their situation is worsened by the increased presence and activities of organized groups, safety and security issues in the camps, limited livelihood opportunities and food insecurity that continue to undermine their well-being and protection and expose them to increased threats and GBV. Natural disasters also continue to have a disproportionate effect on women and girls' safety.

Recommendations

- Strengthen and/or establish WGSS to create dedicated spaces for women and girls within camps, providing a secure environment for them to engage in activities, receive support, and report incidents of GBV.
- Increase awareness campaigns on GBV prevention focusing on the rights of women and girls, support services, and community involvement.
- Enhance access to specialized GBV services through improved coordination with relevant service providers.
- Mitigate GBV risks by mainstreaming GBV considerations across all Sectors.
- Strengthen integrated GBV/sexual and reproductive health services and awareness through community mobilization.
- Promote localization through collaborating with women-led organizations and local NGOs to enhance programme reach and effectiveness in GBV programming.
- Promote peace and security by designing programmes that work closely with the local community and involve women and youth.
- Continue social behavioral change interventions to transform gender norms and promote GBV reporting.
- Advocate for favourable laws and policies that promote the well-being of GBV survivors to reduce dependence on the traditional justice system.
- Continuously strengthen the capacity of GBV service providers to respond effectively.

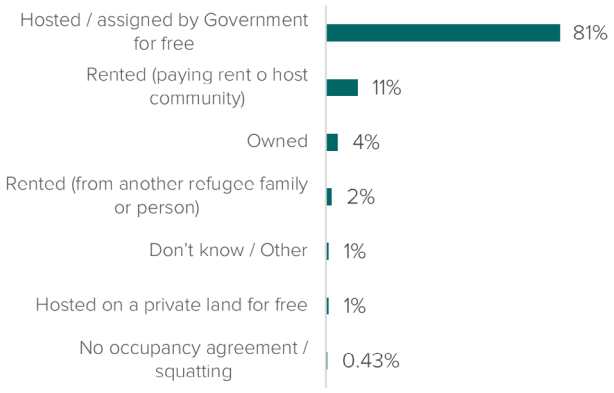
SHELTER-CAMP COORDINATION AND CAMP MANAGEMENT

Ninety-seven percent of Rohingya households lives in emergency shelters, exposed to insecure conditions and highly vulnerable to disasters.

Occupancy

Most (81%) Rohingya households have government-assigned shelters which they inhabit for free, however, 12% are renting their shelter space or paying fees to host community members or other refugee families. This suggests a high dependency on government-provided shelters or informal arrangements. Rohingya households also do not have sufficient documentation to ensure security of tenure should there be significant policy shifts pertaining to their shelter occupancy as 89% do not have any written occupancy agreement. While ISNA results showed that 90% of the Rohingya households do not believe that they are at risk of eviction, at least 2% of households have already experienced eviction at least once in 2024. From the recent cases, there were 771 evictions[49] (see analysis under Protection).

Graph 42: Type of occupancy agreements of Rohingya HH



50. Cox's Bazar, Bangladesh Protection Sector (2024). Factsheet: Rohingya Housing, Land and Property Issues in Cox's Bazar, Bangladesh January- August 2024. Document unpublished- please reach out to Protection Sector.

Shelter

Rohingya households continue to live in temporary emergency shelters (97%) highly vulnerable to disasters, such as flooding, landslides, cyclones, and fire. The remainder live in collective shelters (2%) or in makeshift (self-constructed) shelters, tents, or unfinished/non-enclosed buildings (1%). The inconvenience of living in temporary emergency shelters limits the living space available for a household with a standard family size of five people. About 90% of the households have modified their shelters to have at least three rooms. That said, the majority (75%) of the households said they have sufficient and functional cooking space, with most (69%) reporting enough space for sleeping and sufficient space for food and water storage (82%). Despite this, there is a critical need to implement improved shelter designs to mitigate the risks of natural hazards and fire incidents in the tightly packed camp environment.

Energy

About half (58%) of Rohingya households reported having a reliable lighting source, with 30% experiencing issues with their lighting and 11% mentioning unreliable lighting. To reduce the negative consequences of using firewood for cooking, the Sector has been providing liquid petroleum gas (LPG) as an alternative household cooking fuel. Despite efforts to cover all households with LPG access, 23% of households still use firewood. In addition, 12% of households have either sold or rented their LPG supply to other families in the camps.

Graph 43: Types of shelter of Rohingya households

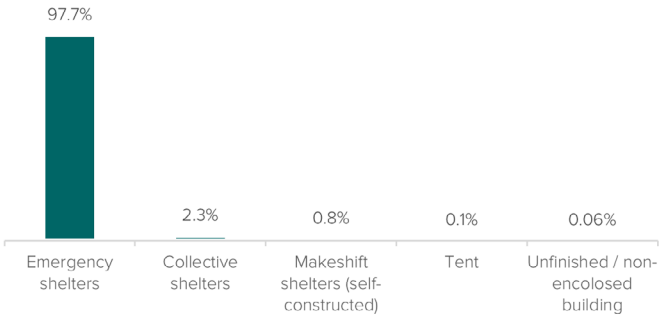
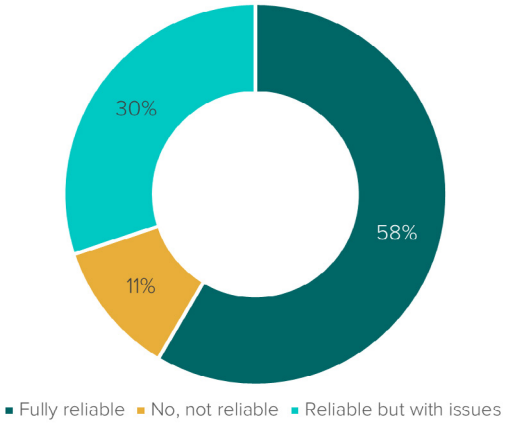


Chart 6: Rohingya HHs perception of lighting reliability in their shelters



Non-food items

There are significant gaps in NFI provision to Rohingya households due to funding constraints. The five most important and in-demand items were mosquito nets (58%), kitchen sets (53%), blankets (45%), solar panels/lamps (43%), and bedding (37%). These essential household items are urgently needed to improve household living conditions.

Space constraints

There are almost one million refugees in Cox's Bazar living in a 24.1 square kilometer area. In 2024, approximately 50,000[50] new arrivals from Myanmar also entered the camps and are largely sheltered in the homes of other refugee households in addition to new births. Twenty-three camps have allotted space for 30 m^2 per person, while eight camps have only 15 m^2 per person on average, underscoring the scale of the challenge.[51] There were almost 94,000 shelter repairs outstanding at end-2024.

Recommendations

- Upgrade makeshift shelters and improve the quality of collective shelters. Transition from current shelters to more weather-resilient and safer shelter designs.
- Strengthen tenure security for the households at risk of eviction and ensure that formal occupancy arrangements (e.g. rental agreements or other documentation) are promoted to mitigate the risk of displacement.
- Encourage all households to adopt disaster preparedness measures ahead of anticipated natural hazards, such as tying down shelters to withstand wind.
- Enhance cooking and storage facilities and address the issues faced by households with insufficient or non-functional cooking spaces and inadequate storage by improving the layout and design of shelters. Providing standardized, functional cooking areas and sufficient storage capacity can alleviate these service gaps.

50. Estimated new arrivals based on population projections used for 2024 JRP planning.
51. Cox's Bazar, Bangladesh SCCCM Sector (2024). Project Monitoring 2024. Document not published, please reach out to the Shelter-CCCM Sector.

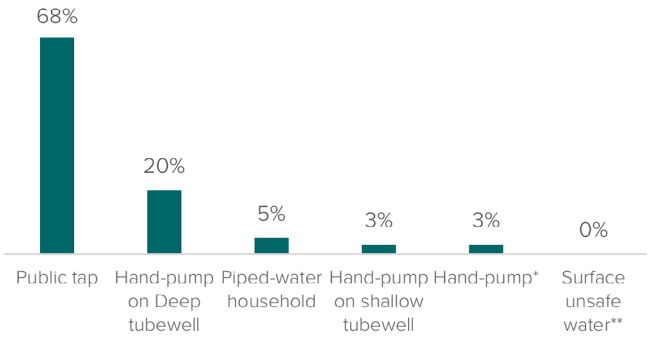
WATER, SANITATION, AND HYGIENE

Significant improvements have been made to the water supply, sanitation, and hygiene practices of Rohingya households over the years.

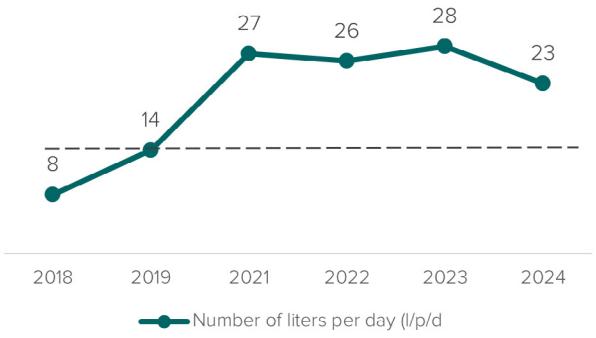
Water

Water supply in the Rohingya refugee camps must be reinforced as only 68% of households are using WASH tap-stands as their primary water source, with the remainder using hand-pumps/tubewells (20%) or a piped water source (5%) (see graph 44). The majority (85%) of households reported having sufficient water to meet household needs but more efforts are needed to support the 15% who reported that they do not.

Graph 44: Sources of drinking water of Rohingya HH



Graph 45: Average litres of water per day collected by the Rohingya HH



Latrines

While all beneficiaries have access to communal latrines, ISNA found that 9% of the beneficiaries have built their own latrine at household level. Amongst them, 60% were constructed through their own arrangements, while 40% were supported by humanitarian organizations. It is important to note that the use of private latrines may not necessarily be positive as these are generally over-flowing due to a lack of maintenance and poor management.

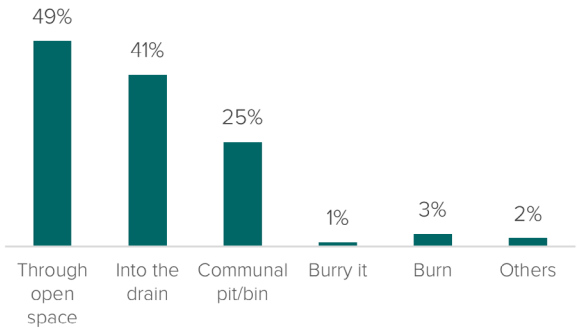
Bathing space

The vast majority (90%) of household's report having built their own household-level bathing spaces to provide more privacy for women. These bathing spaces are multi-purposed for laundry (77%), washing dishes (73%), handwashing (70%), and urinating (62%).

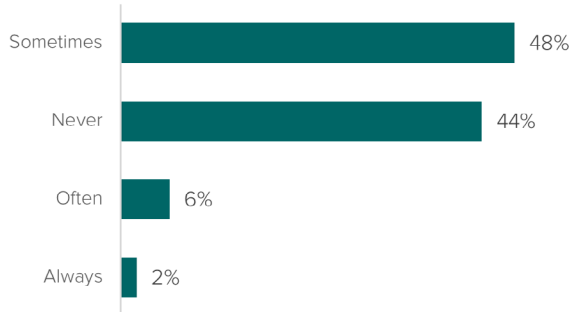
Solid waste

Solid waste management has been a major priority in recent years, which has led to significant improvements. Only 8% of Rohingya households reported visible waste in the vicinity of their shelters and 84% are using a two-bin system with waste segregation. Waste is also collected by volunteers on a daily basis, according to 87% of households, indicating the success of the household collection system.

Graph 46: Practices of Rohingya HH in disposing their uncollected garbage



Graph 47: Rohingya HH who frequently find visible waste in their vicinity



Hygiene

In 83% of Rohingya households, women and girls received their menstrual hygiene management kits on time with high satisfaction with the quality of kits provided (34% very satisfied, 62% satisfied). On handwashing, 86% households knew at least three means to protect themselves from diarrheal diseases and 87% identified at least three critical handwashing moments. These rates are all well within global humanitarian standards for hygiene.

Prevailing risks and vulnerabilities

Only 50% of Rohingya households who have family members with disabilities have good access to sanitation facilities, highlighting the need to reinforce access for such vulnerable refugees. As only 68% of women feel safe using communal latrines at night, misuse of bathing places in Rohingya shelters is common.

Despite improvements in the delivery of WASH services through the years continued efforts are required to sustain existing initiatives efficiently and effectively and address persistent gaps. For instance, only 50% of persons with disabilities have acceptable access to sanitation facilities and one third (32%) of Rohingya households have female members who report not feeling safe using communal latrines at night, leading to misuse of the bathing places for urinating and defecating.

Recommendations

- Develop policy around privatization of WASH infrastructure to avoid the negative consequences of the ad hoc privatization of WASH services.
- Continue the collaboration with the Livelihoods and Skills Development Sector on menstrual hygiene management.
- Continue cost-efficient and effective solid waste management practices at the household level.
- Transition from hygiene promotion to community engagement.
- Enhance the privacy of bathing places and WASH service accessibility for people with disabilities to improve the inclusion of Rohingya women and other refugees with specific needs.
- Identify specific WASH service gaps per camp and target these areas to remove the disparities between camps and service providers.

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