

COVID-19 & Secondary Impacts

Short and long-term impacts of existing COVID-19 containment measures in Rohingya Refugee Camps

As of 5 July 2020, the WHO and the Government of Bangladesh reported 53 confirmed cases of COVID-19 in the refugee camps and 2,776 in the host community in Cox's Bazar (WHO 06/07/2020). It is highly likely that these low case numbers are more indicative of negligible testing than of the actual spread of the virus; the true incidence of the disease is unknown. Anecdotal reports from humanitarians operating within Cox's Bazar, both with the host community and Rohingya refugees, suggest that COVID-19 has spread extensively through both Rohingya refugee camps and the Bangladeshi host community.

This report serves as an update to ACAPS' March 2020 report ([here](#)). It touches on major information gaps that impact the response's ability to understand the current state of the pandemic in Cox's Bazar and **aims to draw attention to the potential negative secondary impacts resulting from existing COVID-19 containment measures.**

While containment measures are essential to reducing the spread of the virus, they create barriers to the availability, accessibility, awareness, quality, and utilization of critical services and livelihood opportunities, leading to an immediate decrease in well-being. Severe consequences are already visible in the camps and conditions are expected to deteriorate further over the long term. Given existing mistrust in the health system and in authorities, building community trust and working with the Rohingya will help address major challenges with the testing and reporting of symptoms. It will also mitigate the secondary impacts of COVID-19 from the associated containment measures, such as a high risk of increased mortality and morbidity from non-COVID-19 related health conditions.

Methodology

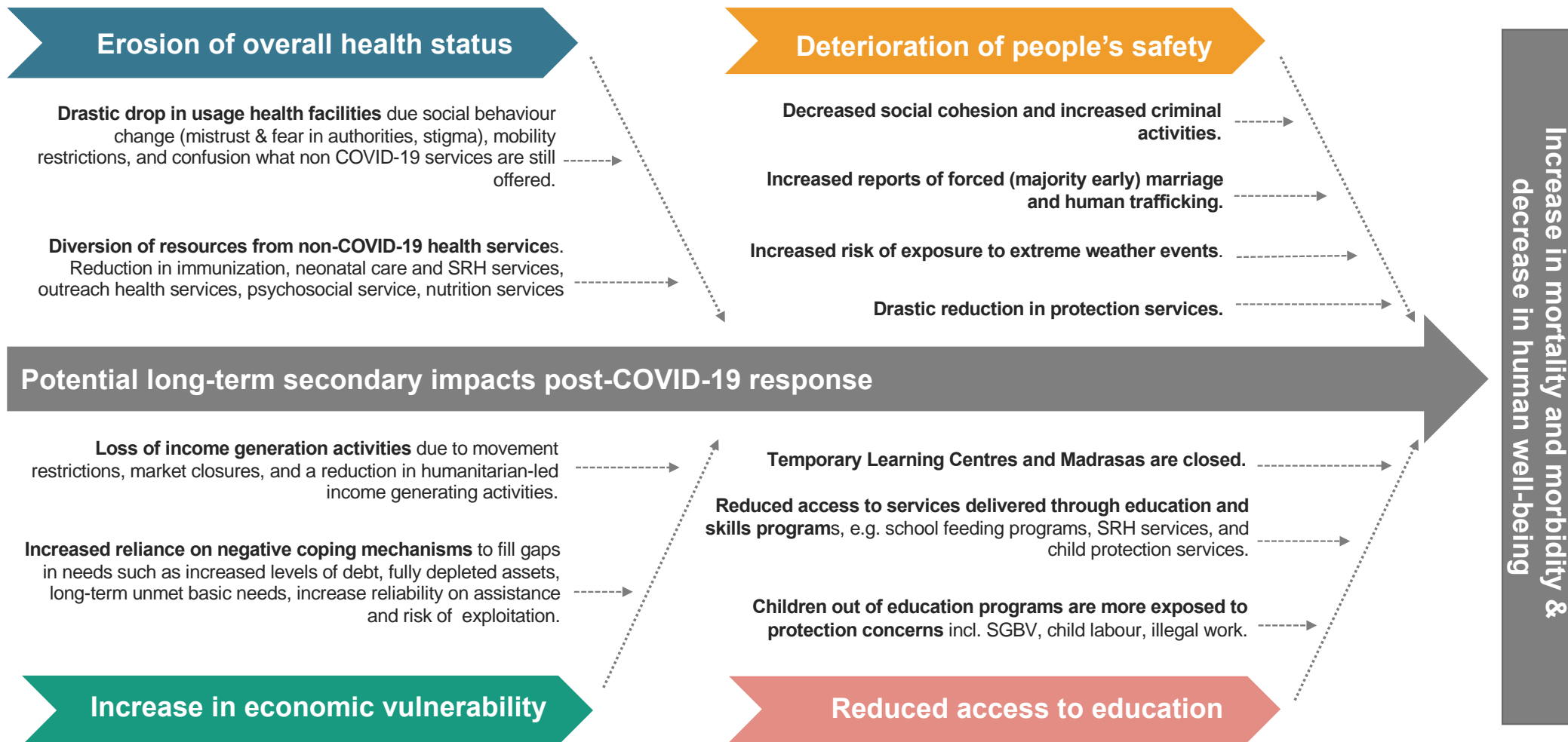
This report presents an analysis of publicly available secondary data that has then been sense checked by actors from various disciplines currently operating with the Rohingya refugees in the camps.

Limitations

This document is designed to give a brief contextual overview and relies mainly on publicly available sources. It should not be used without additional and more specific research to inform preparedness and response planning. As this is an unprecedented and evolving situation, the timing of this report should be taken into consideration. The full extent of secondary impacts is still unknown as the COVID-19 response is ongoing. As such, the potential impacts are presented in this report as possible short and long terms consequence based on the current situation.

Key considerations

- There is an **urgent need to mitigate and address the long-term secondary impacts of COVID-19 containment measures** to save lives and relieve people of their suffering.
- As testing is likely insufficient to understand the epidemiology of COVID-19 in the camps and host communities, **humanitarian agencies should shift their focus to treatment and care.**
- More focus needs to be placed on **improving trust in health facilities and camp authorities.** Mistrust has led to low consultations rates and a lack of willingness to report COVID-19 symptoms and to consent to testing.
- **Disaster risk mitigation and preparedness activities are essential given the coming monsoon season**, especially as operational actors will have a reduced capacity to address the needs resulting from shelter damage and relocation.
- The **reintroduction of protection as an essential service** could reduce the use of negative coping strategies and support families.



Situation overview

The Institute of Epidemiology Disease Control and Research (IEDCR) field laboratory for COVID-19 testing began operating at Cox's Bazar Medical College (CBMC) on 2 April. The increase in capacity to process test samples when the field laboratory gained an extra PCR machine at the end of May did not coincide with significantly more testing. Consent from Rohingya refugees to be tested decreased drastically over the last month (WHO 03/06/2020). In June, an estimated average of 8 test samples were collected per day in the camps, reduced from 11 test samples per day in May. A total of 700 tests were conducted in the camps since testing began in April 2020, compared to 16,220 tests in the host community within the same timeframe (WHO 06/07/2020). Despite this, positive COVID-19 cases have been detected in 20 of the 34 camps, with a maximum of nine cases in one camp.¹

One of the main contributing factors to the low consent rate amongst Rohingya refugees is that, once tested positive, the individual must be transferred to an Isolation and Treatment facility and their contacts may be transferred to quarantine facilities (Health, WASH, CWC Sectors, 06/2020). As of 1 July, only 37 Rohingya refugees were in quarantine facilities in the camps (WHO 02/07/2020). The fear and unwillingness to be admitted to these facilities is due to the lack of trust in both the health system and the camp authorities. This lack of trust stems from a combination of negative experiences with health staff pre-COVID, collective memory of ill treatment in hospitals in Myanmar, an unwillingness to be separated from their families, reports of mistreatment from those first suspected of contracting COVID-19 in the camps, and a misunderstanding of what is provided at these facilities (Galache C 03/2020, Lowenstein A 2015, HRW 2013, ACAPS 04/2020, IOM ACAPS 06/2020). Stories of those who were among the first people suspected to have COVID-19 helped form public perception around the process, and some described the experience as frightening because they felt forced to test and were uninformed about the process and the isolation and treatment facilities (Amnesty International 06/2020). Many believe that the facilities are inadequate and essential items provided, such as food, are insufficient. Some are reportedly unaware that treatment is also available, and others believe they may be killed or left to die in these facilities (Discussion with operational actors in Cox's Bazar 06/2020, IOM, ACAPS 06/2020).

Humanitarian organizations have raised serious concerns about the risk of sensitive data protection regarding COVID-positive test results, with incidents of personal information having been leaked to the media in the past. This has contributed to reluctance of the Rohingya to consent to testing as it may result stigmatization and isolation from the rest of the community (Discussion with operational actors in Cox's Bazar 06/2020, Protection Sector 05/2020).

Popular mistrust and the COVID-19 pandemic resulted in a 50% decrease in medical consultations in the camps over the past three months, with many people reportedly seeking alternative healthcare for their symptoms, such as turning to pharmacies and traditional healers (WHO 21/06/2020, IOM ACAPS 06/2020). There was a recorded two-thirds reduction in total Acute Respiratory Infections (ARI) consultations, indicating changes in specific health seeking behaviours (WHO 21/06/2020).

Given the low number of tests, official cases being found across 20 camps, and reduced access to and trust in health facilities, some health actors fear widespread community transmission in the camps. If that is the case, the situation appears on the surface to be less critical than previously predicted, with health actors and other field responders reporting that most people are presenting mild symptoms (Discussion with operational actors in Cox's Bazar 06/2020). However, without it is not possible to draw conclusions on the primary impact of COVID-19 in the camps as health actors and researchers do not have enough available data.

Given low testing rates, reluctance among Rohingya refugees to be tested, and emerging information on the harmful secondary impacts of containment measures, the humanitarian response needs to consider increasing focus on treatment and the mitigation of secondary impacts. This could have major consequences for the wellbeing of Rohingya refugees in both the short and long term.

Secondary impacts of the COVID-19 crisis

On 25 March, in an attempt to reduce the risk of COVID-19 transmission in the camps, the Refugee Relief and Repatriation Commissioner (RRRC), on behalf of the Government of Bangladesh, published guidelines to significantly reduce the humanitarian footprint in the camps. As a result, many programmes have been suspended; those deemed essential continue to operate with limited field presence and have had to make important changes to programme delivery to comply with physical distancing and hygiene procedures.

Under current guidelines, only critical services and assistance are permitted, including all health and nutrition services, WASH activities and services, Liquefied Petroleum Gas (LPG) distributions, information hubs for COVID-19 awareness sessions, food distributions, and the reception of new arrivals and family tracing. All shops and markets, excluding specific kitchen markets in the camps, are closed and all non-essential programs have been suspended until further notice, including the drawdown of protection programs, site management work, most shelter/NFI activities, livelihood activities, education and learning centres, friendly spaces and community centres, and training facilities (RRRC 08/04/2020).

¹ As of 5th of July 2020, official cases have been detected in camps 1W, 2E, 2W, 3, 4, 5, 6, 7, 8E, 8W, 9, 10, 11, 12, 14, 18, 22, 24, Kutupalong RC and Nayapara RC.

While the aforementioned restrictions allow the continued delivery of ‘life-sustaining’ activities, the measures impact people’s ability to access critical services, their feelings of safety and security, and drastically reduced livelihood opportunities. The longer such extensive measures are applied in camps, the higher the risk that the secondary impacts of the COVID-19 crisis will be negative and long-term.

Erosion of the overall health status of the population

The **drastic reduction in consultations with healthcare providers** (over 50% in last 3 months) poses a risk to long-term health as both minor and chronic health issues go unchecked and unaddressed, potentially increasing the average mortality and morbidity of non-COVID-19 diseases. Many reports attribute the reduction in health consultations to widespread distrust in healthcare services among the Rohingya, restricted movement between camps, and misinformation resulting in confusion as to whether health services continue operating and if non-emergency or non-COVID-19 cases can access services (WHO 21/06/2020, TWB, BBC Media Action 05/2020, IOM ACAPS 06/2020).

The **diversion of resources to the COVID-19 response**, shortage of medical personnel, and difficulties getting additional staff in country has had a negative impact on the delivery of regular health services. This includes immunization, sexual reproductive health, psychosocial support, and the treatment of non-communicable diseases (NCDs) (ISCG, 04/2020). Rohingya refugees who visited clinics since the outbreak began reported a deterioration in quality of care, noting that healthcare workers appeared reluctant to approach patients, especially those who presented COVID-19 symptoms (IOM ACAPS 05/2020).

Containment measures led to a **drastic drop in routine immunization (RI) and the Expanded Programme on Immunisation (EPI) coverage** across the camps.

Outreach sessions were temporarily halted due to the risk of COVID-19 transmission, and vaccination teams had difficulty moving to and within the camps. The lockdown also impacted the availability of vaccine and logistics supplies. The dramatic drop in RI coverage from birth to 16 months is highlighted in the table 2 (Health Sector meeting minutes 24/06/2020). EPI vaccine coverage has dropped to 6% or below in both Ukhiya and Teknaf.

Average RI coverage across all camps:	Jan-20	May-20
At birth	62%	23%
At 6 weeks	50%	13%
At 10 weeks	54%	9%
At 14 weeks	80%	10%
9mths & 16mths	21%	2%

2 More than one vaccine is administered for RI at each of the age milestones outlined in the table above, so to get the above percentages the average coverage for each vaccine recorded according to the age milestone

According to the WHO in Bangladesh, the low rate of current immunization coverage has the potential to lead to an outbreak of vaccine preventable diseases (VPD). If that were to happen, the health system would not have the capacity to manage another outbreak. The Civil Surgeon Office and RRRC recently approved the resumption of some outreach RI sessions in health facilities starting on 1 July, with strict hygiene and physical distancing measures (WHO 10/06/2020).

Operational agencies have reported that **many older people in the camps suffer from chronic illnesses** and rely on home-based outreach services to deliver medical and psychosocial support. Their mental health is at risk and it is virtually impossible to provide support services during lockdown. This is compounded by the fact that many older people are unable to access alternative online support or have a hearing disability that makes phone communication difficult (HelpAge 22/05/2020). Home-based physical distancing and limited family contact has been encouraged to protect those who are most susceptible to COVID-19, such as older persons and those with comorbidities (Health, Shelter, WASH Sectors, 05/2020). However, this contributes to a decrease in access to essential services and could result in an increase in feelings of isolation and the deterioration of mental health.

Health actors also fear an **increase in maternal and child deaths** resulting from the disruption of health systems, diversion of regular services to COVID-19, and limited access to food. Despite guidelines issued by the Sexual and Reproductive Health (SRH) Working Group on how to continue providing and prioritising maternal health care during COVID-19, some actors report that they have had to reduce the recommended number of antenatal consultations for pregnant women in their clinics (ACAPS discussions with health actors operating in Cox’s Bazar 29/06/2020). The number of women delivering at the hospital has decreased and fewer women are attending routine reproductive healthcare appointments (WHO, 06/2020).

All nutrition facilities and services were scaled down to comply with COVID-19 containment measures, to reduce crowds, and to facilitate physical distancing. In addition, outreach services were suspended. In May 2019, 316,296 children under 5 years old were screened for acute malnutrition compared to May 2020, where 100,424 children and Pregnant and Lactating Women (PLW) cumulatively were screened for malnutrition (ISCG 05/19, 06/2020). To offset the risks of this scale-down, small scale initiatives involving community nutrition volunteers training Rohingya mothers to identify new cases of malnutrition in households are ongoing (UNICEF 06/2020). However, if essential outreach nutrition services continue to be put on hold, the significant decline in the prevalence of gross acute malnutrition (GAM) in the camps – from 19.3 percent after the influx to 10.9 percent in October 2019 – could be reversed (JRP 2020). The prevalence of anaemia among children between 6 and 23 months (59.6 percent) and

was combined to produce an overall average per age marker. Therefore, this table is only designed to give an overall indication of RI drop and cannot be used for planning or any other analysis.

stunting among children under 59 months (32.6 percent) was a major public health concern pre-COVID-19. The reduction in services and drastic drop in consultations will have immediate health repercussions along with dangerous negative implications on development and growth (JRP 2020).

Deterioration of people's safety

The Rohingya refugee population, the host community, and protection actors operating in Cox's Bazar all reported an increase in protection issues in the camps and the surrounding areas as a result of COVID-19 and the subsequent containment measures.

Decreased social cohesion and increased criminal activities have been reported by both the Rohingya and the host community due to a decrease in income, limited resources, fear and reduced humanitarian presence in the camps, and limited protection monitoring (Protection Sector meeting minutes, 04/2020, IOM ACAPS 05/2020). Without major humanitarian interventions and resumption of livelihood opportunities to support those most in need, both Rohingya and Bangladeshi, social cohesion will continue to deteriorate as people turn to negative coping mechanisms to meet their basic needs.

Increased rates of intimate partner violence, sexual and gender-based violence, and harmful practices towards children, including early marriage and child labour, have been reported by humanitarian protection staff and documented through an increased use of referral pathways by non-protection staff (Protection Sector meeting minutes, 04/2020, CARE, OXFAM, UNWomen, ISCG 05/2020, ACAPS 06/2020). As safety and livelihoods are threatened, levels of desperation and frustration have increased. This frustration is often expressed violently within homes. Reduced humanitarian presence and the suspension of some protection activities have made it extremely difficult to conduct protection monitoring or to effectively refer people to protection services. Limited and/or delayed referrals for life-saving case management results in loss of trust in the protection service system at best and can be fatal at worst (ISCG, 05/2020)

There are **increased reports of forced (majority early) marriage and human trafficking** as people are pushed to rely on negative coping mechanisms, fear for the safety and security of their daughters, or do not feel they have alternative options. The child protection sub-sector reported an increase in child marriage and child trafficking in May (ISCG 06/2020). Reports from camps suggest that adolescent girls and women are being sent to Malaysia for marriage, often by their families who are desperate and lack money for dowry (Discussion with operational actors in Cox's Bazar 06/2020). According to research conducted by Fortify Rights in March 2019, many Rohingya men who travelled alone to Malaysia in August 2017 are now financing these perilous journeys. Both Malaysia and Bangladesh have stated that, due to COVID-19, they will no longer accept Rohingya refugees, nor will they rescue boats in international waters (HRW, 05/2020). It is estimated

that thousands of Rohingya people have attempted the journey in the past 3 months and hundreds are believed to be currently adrift on cramped fishing boats between the Bay of Bengal and the Andaman Sea (Amnesty International, 06/2020). For the Rohingya that manage to disembark in Bangladesh, some have been reunited with their families in the refugee camps after a period in quarantine while an estimated 300 people have been transferred to Bhasan Char island (HRW, 06/2020).³

Increased risk of exposure to extreme weather events such as landslides and flooding as the monsoon season begins. Between 1 April and 5 July 2020, the beginning of the monsoon period, a total of 18,823 households were impacted by small-scale weather-related incidents, including 16,354 partially damaged homes and 2,099 completely damaged homes (NPM, ISCG, Site Management Sector, 06/06/2020). Compared to last year's incidents recorded across the entire monsoon period, this year's monsoon season already looks set to surpass the number of households impacted. Between April and November 2019, a total of 19,110 households were impacted by small-scale weather-related incidents, which included 11,942 partially and 1,493 totally damaged shelters, and 3,972 displaced households (NPM, ISCG, Site Management Sector 02/2020). During the 2019 monsoon season, most incidents reported in July were the result of landslides, soil erosion, winds, rain, storms, and flooding. Due to COVID-19 containment measures and the shift to critical services, humanitarian actors have less capacity to respond. Key shelter and site development activities such as the regular upgrading of household shelters and fortifying of essential public facilities within the camps, normally conducted in the lead up to the monsoon, slowed down and or were not completed, leaving those residing in the camps increasingly vulnerable to natural hazards (RRRC 08/04/2020, ISCG, 04/2020). The temporary relocation of households with damaged shelters to communal shelters or learning centres, or alternative measures such as staying in the shelters of extended family members, are no longer a safe and viable solution due to the risk of COVID-19 exposure (ISCG, 06/2020).

Increase in economic vulnerability

Pre-COVID-19, 94% of Rohingya refugees were considered highly or moderately vulnerable and in need of humanitarian assistance to meet their basic needs (WFP 04/2020). The limited income generation activities that were available pre-COVID-19 have been disrupted by movement restrictions, market closures, and a reduction in humanitarian-led income generating activities, such as volunteering for NGOs or participating in Cash for Work programs. An April 2020 study by Yale University found that of 909 households surveyed, 72% of Rohingya refugees and 60% of Bangladeshis were unable to buy essential food items in the last seven days and of those, between 43%-47% had skipped meals or reduced food portions (Lopez-Pena P, Austin Davis C, Mushfiq Mobarak A & Raihan S 11/05/2020).

³ The humanitarian community are concerned for their wellbeing as the UN has not had contact with these people since they were transferred to the island 6 weeks ago.

Pre-COVID-19, **almost 80% of Rohingya households relied on negative coping mechanisms to meet their basic needs**, such as relying on less preferred and less expensive foods, borrowing money, relying on friends and family for help, selling assistance and relying solely on assistance which is insufficient to meet all their basic needs (WFP 04/2020). All these mechanisms are less viable in the current context, making Rohingya refugees even more reliant on humanitarian assistance and simultaneously without the means to supplement this assistance to meet their basic needs. Although Rohingya refugees receive universal food assistance, movement restrictions gravely affect the ability of some households to collect it. Some households that relocated to a different camp and do not yet have updated registration to reflect their relocation are now unable to return to their previous camp to collect assistance (Discussion with operational actors in Cox's Bazar 15/06/2020). Refugees have also reported a decrease in the diversity of food assistance, with far less fresh produce due to changes in food distribution modalities and market shortages. Families now receive primarily rice, lentils and oil, and lack the means to buy fresh fruits and vegetables (WFP 03/2020, IOM ACAPS 05/2020). As a result, many refugees are concerned about their health and the health of those most vulnerable. Given the reduced access and diversity of food, Rohingya children are at an even higher risk of suffering from acute malnutrition.

The reduction in livelihood opportunities, changes in assistance, and barriers to assistance will likely result in increased levels of debt, fully depleted assets, and increased reliance on humanitarian assistance that does not fulfil basic needs, leading to protection risks such as eviction, forced and/or exploitative labour, a decrease in overall health, and food insecurity and malnutrition. Those who were more economically vulnerable pre-COVID-19, such as single female headed households, are more vulnerable to the secondary economic impacts as they are less likely to have savings or assets that could help them absorb the initial shock and mitigate the long-term negative impacts (CARE, OXFAM, UNWomen, ISCG 05/2020, ISCG, 11/19, ACAPS 12/2019).

Lack of access to education

With the closure of Temporary Learning Centres (TLCs) and Madrasas due to COVID-19 containment measures (RRRC 08/04/2020), many Rohingya children continue their learning from home with small-scale support from Rohingya volunteers and teachers and the provision of stationery and learning materials (UNICEF 02/06/2020). The diversion of what little humanitarian assistance remains in the camps to life-saving assistance has resulted in a short-term pause in education and skills development for all ages groups (ISCG 04/2020). The child protection sub-sector reported that the current lack of recreational and learning materials for children is contributing to psychosocial distress (ISCG 30/06/2020). Consultations by the IOM Communicating with Communities (CwC) team in May highlighted the extreme importance of education to young Rohingya. Education is viewed as a productive way to pass time, a reason to leave crowded shelters, and an outlet for future opportunities (IOM ACAPS 05/2020). Youth directly linked lack of education to a lack of jobs and thus, early marriage. Children, adolescents, and

youth no longer have access to essential services delivered through education and skills programs, such as food (through school feeding programs), sexual reproductive health awareness and services, and child protection services, all of which have been temporarily suspended (ISCG 05/2020). The potential long-term implications are extremely concerning. Research suggests that the longer children, especially girls, are out of school, the less likely they are to return. School attendance among adolescent girls (from the age of 12 and above) was disproportionately low pre-COVID-19 compared to boys. According to the Joint Multisector Needs Assessment (JMSNA), only 54% of boys and 34% of girls between the ages of 12-14 were attending TLCs, and attendance further decreases while the gap between boys and girls widens for those between the ages of 15-18, with 13% and 2% respectively attending TLCs (ISCG 11/2019). For the girls that do attend school, the longer they are out of school the more vulnerable they become to sexual and gender-based violence (SGBV), early marriage, and early pregnancy. Boys, meanwhile, are exposed to a higher risk of being forced into child labour, including illegal work (ISCG 06/2020, Centre for Global Development 16/03/2020; World Bank, 19/03/2020; UNDP, 26/10/2015; HRW, 03/04/2020). Both outcomes are accompanied by a slew of potential negative health implications.

Who are the most at-risk of secondary impacts?

Those who have less access to public spaces due to mobility and social norms, have fewer assets and were economically poor pre-COVID-19, or require regular medical support are most at risk as they have more difficulty accessing assistance and services despite needing the most support.

The people or households that are likely to be the most vulnerable are:

- Single female headed households and those without a working age male.
- People with disabilities
- Older persons, especially those who are heads of households.
- People suffering from chronic illness or those who have regular non-COVID-19 health issues that require support from health professionals, including pregnant women.
- Large economically vulnerable families, likely those with more than five members.

Please refer to the following reports for further information:

REVA 3 (WFP 03/2020), COVID-19 Explained 5 (IOM ACAPS 05/2020), Rapid Gender Analysis (CARE, OXFAM, UNWomen 05/2020), JMSNA (ISCG, 11/19), Vulnerability study (ACAPS 12/2019).