INTERNATIONAL RESCUE COMMITTEE

UNDER-REPORTED AND UNDER-ADRESSED: GENDER BASED VIOLENCE AMONG ROHINGA REFUGEES IN COX'S BAZAR

NOVEMBER 2021

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Under-Reported and Under-Addressed:

Gender-based violence among Rohingya refugees in Cox's Bazar

The International Rescue Committee (IRC)

This report is the third publication by the International Rescue Committee (IRC) on the incidence of gender-based violence (GBV) among Rohingya refugees in Cox's Bazar, Bangladesh. Previous reports include *The Shadow Pandemic: Gender-based violence among Rohingya refugees in Cox's Bazar, Bangladesh* (June 2020) and *GBV Trends Among Rohingya Refugees in Cox's Bazar: COVID-19 Update* (January 2021).

Using data collected from IRC's Integrated Women's Centres and integrated GBV-health programme sites across Cox's Bazar, alongside evidence from interviews with IRC's GBV case workers, this report offers two sets of findings. The first (page 1) are the consolidated findings of IRC's GBV screening data over a 24-month collection period, from 2019 – 2021, revealing the continuity of reported GBV rates in this time period. The second (pages 2 and 3) are the findings of both IRC GBV screening data and GBVIMS data from October 2020 – June 2021, showing the most recent trends in GBV reporting.

2019 – 2021 findings

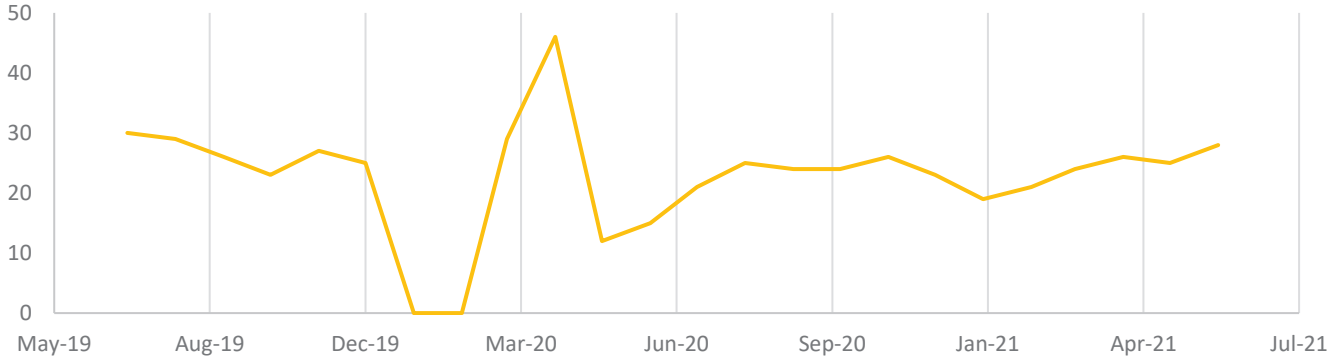
IRC data analysis indicates that on average, one-in-four women and girls screened throughout 2019 - 2021 reported that they were a survivor of gender-based violence.

These levels of reported GBV have remained consistent irrespective of a two-month suspension of GBV screening (in January and February 2020) and the suspension of protection programming as a result of COVID-19 mitigation measures – which hampered women and girls access to services – as well as a data anomaly in April 2020 (explained in our June 2020 report).

Without improvements in both the availability of services offered to women and girls, and increased funding of GBV and protection programming including both prevention and response activities – in 2020, GBV sub-sector funding reached less than 18% of requirements and funding data is unavailable for 2021 – GBV will continue to be under-reported and under-addressed.

Previous reports have emphasised that fluctuations in the availability of protection services (including community awareness sessions) have had an impact on the reporting of GBV. As a result, GBV response actors have adapted to maintain case management, including through telephone services during lockdown. Despite fluctuations, suspensions and adaptations in access to GBV programming throughout the 24-month reporting period, **baseline reported levels of GBV from screening data remain at an overall average of one-in-four, indicating GBV rates are highly likely to be higher than reported.**

Percentage of women and girls screened who reported incidents of GBV
June 2019 - June 2021



Recommendations

- **Humanitarian NGOs** should design integrated sensitization programmes that encourage behavioural change and awareness raising through strengthening male engagement, particularly within community-based approaches and with Imams, Majhis and other community leaders.
- **Donors** should meet commitments under the Call to Action 2021 – 2026 roadmap to ensure sufficient and timely funding for GBV programming; this can be achieved by significantly increasing flexible, multi-year funding to response plan requirements in order to allow for an expansion in national GBV provision and expertise.
- **The Government of Bangladesh** should commit to the unfettered continuation of protection services, including life-saving GBV programming, clinical care and legal services, throughout all future emergencies and COVID-19 lockdowns. The Government should also facilitate the delivery of the humanitarian response through timely processing of FD7s and visas to expand access to vital protection services for women and girls in the response.
- **UN Agencies and NGOs** should work to improve GBV needs assessments in order to better identify risks of GBV for women and girls.

IRC GBV screening data October 2020 – June 2021

The reporting levels in IRC's screening data in 2021 show that an average of one-in-four of those screened reported incidents of GBV. However, even these figures, as with previous datasets, are highly likely to be an under-assessment. The 2020 Joint Response Plan recognises this reality: given the enormous social, cultural and psychological barriers to reporting GBV in Cox's Bazar "the recorded cases are likely to represent only a small fraction of the overall number".

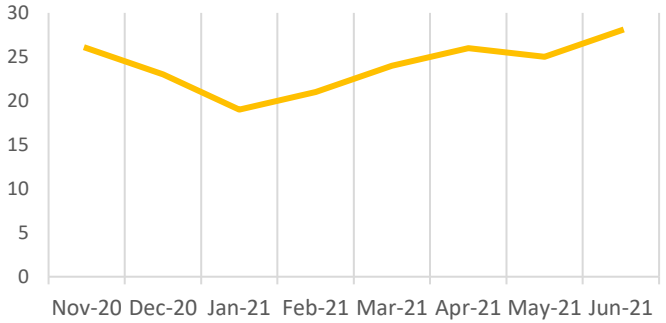
In this reporting period, IRC's data collection was again constrained by restrictions on protection programming imposed by the Government of Bangladesh: during the months of November and December 2020 and January 2021, IRC case workers could screen for GBV in-person, however, from February 2021, restrictions on protection activities were put in place. By March 2021, the Government of Bangladesh limited humanitarian programming only to services defined as lifesaving, during which time IRC was able to send case workers on a limited scale to several camps with prior government approval.

In the months following the implementation of restrictions on protection activities (April – June) the percentage of women and girls reporting incidents of GBV slightly increased. This occurred during a period of reduced reporting overall and therefore is best assessed as a minor data distortion resulting from the reduction in the availability of protection services, further underlining the importance of consistently maintaining access to protection services. The IRC's operational experience in Bangladesh, as stated in our previous report, reveals a direct link between community engagement/sensitization programming with the number of women and girls reporting GBV. When IRC is able to conduct community outreach and prevention activities, the number of women and girls reporting GBV increases. A further trend in IRC's screening data demonstrates a significant time gap (of more than one month) between when GBV incidents occur and when they are reported. Community outreach can play a vital role in addressing this gap through meeting women and girls in safe and secure settings.

"We are not getting all the cases. We see cases all around us, but we can't do anything if they do not tell us"

- IRC case worker

Percentage of women and girls screened who reported incidents of GBV
October 2020 - June 2021



Adaptations to provision: efforts to maintain access to essential protection services

During the period of lockdown across the camps, from March 2021 onwards, GBV referrals and case management were conducted remotely by phone. Remote working inevitably reduces the scale of monitoring and creates further barriers for women and girls to securely report incidents of GBV, for example, because women may feel unable to make or receive a call at home where they may feel insecure or unable to speak openly due to their abuser being present. This trend is reflected in the data on IPV on page 3.

The majority of IRC's GBV cases under case manager were referred to IRC through community volunteers. Community outreach activities are critical to discovering new GBV cases - when women and girls attend health or nutrition facilities they tend to be accompanied by a male relative and consequently feel less safe to share incidents. However, approvals to conduct community outreach during lockdown required volunteers to focus on COVID-19 awareness. Future adaptations to service provision under any COVID-19 lockdown or other emergency should involve improved capacity for community outreach.

In response to difficulties in providing services across the camps, particularly in light of service suspensions during lockdown, the IRC is now training midwives on GBV referral pathways and GBV core concepts to improve women and girl's access to services. Midwives will ultimately act in support of remote case management and refer cases, if/when IRC case workers face movement restrictions as a result of lockdowns or other restrictions on humanitarian access and movement within the camps.

Screening limitations

IRC's screening data is collected at health facilities and IRC's Integrated Women's Centres, where women and girls may choose to share their experiences. It must be presumed that not all women and girls who wished to report incidences of GBV were able to do so or that all women and girls who have experienced GBV want to report the incident. As such, **the data in this update does not represent a GBV prevalence study**, however IRC case workers indicate levels of GBV are likely higher than the data reports.

Instead, the IRC screening data in this report offers a snapshot of consistently frequent reports of GBV despite reporting limitations, demonstrating that much more must be done by all actors in the humanitarian response to address this epidemic of violence against women and girls.

Data sources

This report was produced based on data from the GBVIMS, and GBV screening data from Rohingya refugee camps in Cox's Bazar, Bangladesh.

The IRC's GBV screening data is collected by IRC staff in health facilities, and Integrated Women's Centres. Only women and girls who consent are screened for incidents of GBV, with all anonymised data collected securely under safe and ethical data collection standards at the point of service provision.

GBV Information Management System (GBVIMS) data is collected and securely shared by the IRC through an GBVIMS global tools. GBVIMS data is collected from GBV survivors who are receiving case management services.

GBVIMS data

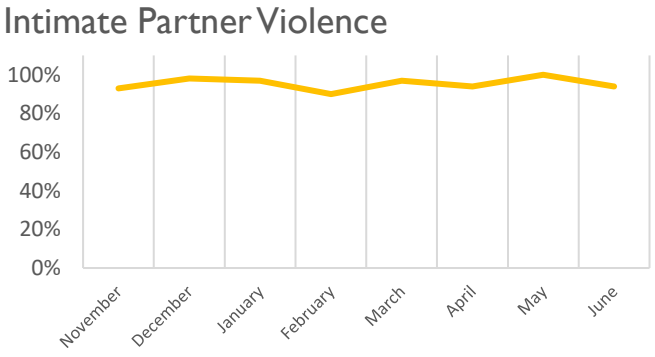
October 2020 – June 2021

Intimate Partner Violence

GBVIMS data demonstrates that throughout this third reporting period, an average of 95% of incidents involved Intimate Partner Violence (IPV), a 1% increase on the previous reporting period.

Focus group discussions with IRC case workers find that as in previous reporting periods, lack of male engagement in GBV sensitization as a part of preventative programming increases the risk of IPV. The 2020 JRP Mid-Term Review notes that in the first half of 2020, only 33% of those reached with GBV prevention information were men and boys – an increase of 11% on the same reporting period from the previous year, but still well below levels needed to support GBV prevention efforts, with no further data available for 2021. This is further exacerbated by the limited availability of sensitization programming. A loss of already limited access livelihoods as a result of lockdown is also likely to have contributed to these high levels of IPV, as indicated in the 2020 JRP Mid-Term Review. Throughout lockdown, there was likely a higher level of GBV as a result. However, it is important to note that IPV is not *caused* by male unemployment – it is the result of unequal power of men over women and patriarchal norms.

Increased male engagement activities, skills development, and community engagement programmes, particularly with influential community leaders such as Imams and Majhis, are vital steps to reduce IPV. In addition, steps are needed to support case workers to address barriers in linking survivors to legal services, and to help survivors understand the importance of Mental Health and Psychosocial Support Services (MHPSS). These actions require consistency of service delivery, greater funding and an expansion in national GBV provision and expertise.



"I was 13-years-old and the oldest child in my family. After my first menstruation, my mother decided to marry me off with a boy as… [he was] financially well-off… I had to agree to this marriage… I am unable to concentrate properly on my house, and my husband always forces me into a physical relationship, which is very difficult for me"

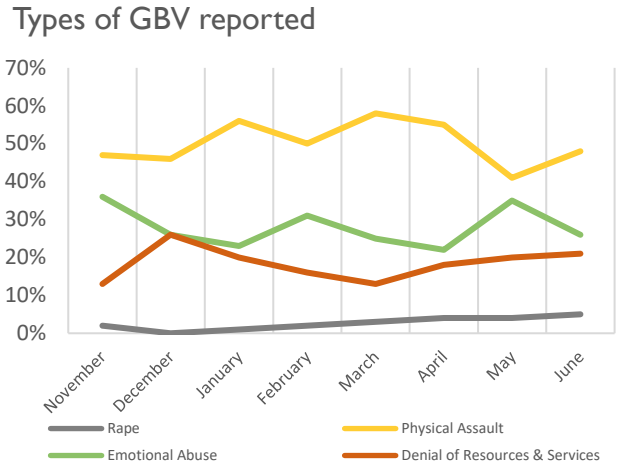
- 16-year-old Rohingya girl under IRC case management

Child marriage

GBVIMS data on forced and early child marriage is extremely limited, with most months data indicating it has occurred in less than 1% of cases. However, evidence from both child protection case management (CPCM) and IRC's focus group discussions (FGD), strongly indicates that forced and early child marriage is higher than reported. This was reportedly a result of interruptions to protection programming - IRC case workers were unable to conduct face-to-face monitoring during all lockdown phases - and consequent interruptions to data collection.

Child marriage is often used as a negative coping mechanism as a result of low food security or income, and as a result, Rohingya families are reluctant to report incidents. Community sensitization programming and improvements in livelihoods opportunities, including for women, would lower the risk for girls to be exploited by men through early marriage. However, child marriage occurs for a variety of other reasons, including: gender norms, an undervaluing of the lives of girls, cultural customs, and weak protection mechanisms. This demonstrates the importance of strong referral mechanisms between child protection and GBV programming, of which IRC is leading efforts to improve.

The 2021 JRP suggests that child protection mechanisms in the Cox's Bazar camps need strengthening, specifically through partnerships between the Ministry of Women and Children Affairs (MoWCA) and the Department of Social Services (DSS) and the Child Protection Sub-Sector (CPSS). However, until reported rates of child marriage in the camps can be more comprehensively assessed through improvements in the funding of the GBV sector and restrictions on protection programming are ended, there remains limited scope even for enforcing Child Protection Minimum Standards.



Types of GBV reported

Physical assault was the primary type of GBV reported in the GBVIMS (in 50% of reports) with reported levels of emotional abuse (28%) and denial of resources, opportunities and services (18%) the next most commonly cited. The frequency of these reports alongside persistently high rates of IPV reporting indicates that the majority of IPV incidents are likely to include physical assault and emotional abuse, three types of GBV often associated with domestic settings in the Rohingya context. Over IRC's three reports, physical assault has consistently been the most commonly cited type of GBV.

While rape and sexual assault reporting remain low, evidence from IRC case workers indicate that rape cases are significantly underreported. These types of GBV also carry by far the most significant risk of reprisal for reporting. Consequently, incidents of this type are likely to be far more common than GBVIMS data indicates.

Conclusions

The continuation of similar reporting rates across IPV, types of GBV and IRC screening data through three report phases in a two-year time span demonstrates how vital it is to renew efforts in GBV assessment, prevention, and response. Without significant improvements in funding as well as programmatic scale and reach, GBV staff will continue to be constrained in their ability to report and address this epidemic of violence.

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