GBV Trends Among Rohingya Refugees in Cox's Bazar

COVID-19 Update

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Acknowledgements

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Front cover image: An IRC staff member speaks to a Rohingya woman in Kutupalong camp, Cox's Bazar. *Habiba Nowrose/IRC*

In June 2020, the International Rescue Committee (IRC) released a report entitled ***The Shadow Pandemic: Gender-based violence among Rohingya refugees in Cox's Bazar, Bangladesh***. Using data collected from IRC women's centres and health programme sites between July and December 2019, the IRC found that despite the enormous social, cultural, and psychological barriers women and girls must overcome when reporting incidents, prior to the onset of COVID-19, one in four women and girls screened in Cox's Bazar was a survivor of gender-based violence (GBV). This update brief offers new data from IRC and partner programme sites from January - October 2020, a period of time in which women and girls "faced an increase in unpaid care work, greater protection risks in and out of their homes, and mental health issues, while simultaneously being less able to access lifesaving services and support" (**JRP**). IRC screening data for this period suggests that despite the significant pre-existing barriers to reporting incidents of GBV outlined in our June *Shadow Pandemic* report, and in the face of the substantial new barriers posed by COVID-19, **reported rates of GBV among Rohingya in Cox's Bazar remain shockingly high, particularly among women and girls in their own homes.**

As GBV and protection risks escalated throughout the onset of COVID-19, funding for these vital sectors declined. In 2020, just 16.8 percent of GBV sub-sector funding requirements and only 50.8 percent of protection sector funding requirements were met by the end of the year (**FTS**). Despite these challenges, protection actors in Cox's Bazar continued to work tirelessly to maintain access to essential services. Over 100 protection, child protection and GBV focal points were deployed alongside Protection Emergency Response Units (PERUs) across all camps, and following a reduction in the presence of protection actors in April, trained community volunteers stepped in to fill gaps in service delivery, enabling the GBV-subsector to reach over 370,000 people between January – July with information on referral pathways (**JRP**).

Findings

Findings in this COVID-19 update combine IRC screening data (Section I) and GBVIMS[1] data (Section II) to reveal trends shared across both datasets. Alongside these two datasets, Key Informant Interviews (KIIs) conducted in July 2020 by the IRC with 60 female Rohingya community members from 15 camps are referenced to assess and qualify the data points.

The IRC's analysis finds that the majority - 94 percent - of recorded GBV incidents in this time period were perpetrated by intimate partners, a significantly higher rate than the 81 percent average indicated in the June *Shadow Pandemic* report. The primary form of GBV reported by women and girls remained physical assault, with spikes in recorded in GBVIMS data found particularly during April, the first month following lockdown in Cox's Bazar, and September, shortly after GBV prevention activities had restarted, suggesting a clear link between availability of GBV services and the ability of women and girls to report GBV incidents. Spikes in physical assault rates during the month of April are also corroborated by the findings of both the KIIs and the UN's Joint Response Plan Mid-Term Review, which observed an overall "increase in sexual and gender-based violence" in this time (**JRP**). Reported levels of rape and sexual assault remain low in these datasets, though given global increases in rates of GBV during COVID-19, as well as barriers to reporting, IRC interviews and experts indicate that these types of GBV are almost certainly underreported. The findings illustrate the necessity of keeping GBV prevention and protection services available.

Limitations of data collection in Cox's Bazar

GBV screening at IRC's health centres in 2020 was either suspended or significantly scaled-back due to restrictions on centre-based programming, while protection programming was simultaneously deemed "non-essential" as part of the Government of Bangladesh's COVID-19 containment strategy. Additionally, health facility screenings do not necessarily ensure a representative sampling and consequently the data used in this update is *not* representative of the prevalence of GBV across Cox's Bazar. It must also be presumed that not all women and girls who wished to report incidences of GBV were able to do so. Instead, a snapshot of IRC's available screening data is presented in Section I - revealing a continuation in rates of GBV within this limited dataset. In Section II, GBVIMS data is analysed to show GBV trends by type. The data also offers an assessment of how the reduction or suspension of services as a result of COVID-19 mitigation strategies has affected women and girls' access to safe spaces and their ability to report incidents.

IRC GBV screening data is collected by IRC staff in health facilities, women's centres and women and girls' safe spaces. 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 and partner organisations through an anonymised and centralised database. GBVIMS data is collected from GBV survivors who are receiving services such as case management or psychosocial services.

Summary of recommendations

- UN agencies leading the protection working group, and GBV sub-working group, as well as the Strategic Executive Group in Dhaka should use all opportunities to advocate to the Government of Bangladesh to ensure centre-based GBV prevention and response services are designated as "essential" (with necessary social distancing) to enable survivors of GBV to access services and heal and recover. In addition, all UN sector leads should ensure appropriate protection and GBV mainstreaming to mitigate the risks women and girls face in accessing essential services.
- The GBV sub-sector should offer sensitisation sessions, training, and technical support on GBV programming and standards to the Refugee Relief and Repatriation Commissioner's (RRRC) office, including the Camp-in-Charge, to establish a more consistent and informed approach towards GBV programming.
- Donors should ensure funding for the GBV response is prioritised in donor strategies and that funding levels are increased for the 2021 Joint Response Plan (JRP) to ensure the expansion of life saving GBV programming.
- International donors should work with the Ministry of Women and Children's Affairs, as well as UN agencies and local and national women's rights organisations, to agree a strategy for the localisation of the Rohingya GBV response.

[1] The GBV Information Management System (GBVIMS) is an inter-agency initiative to collect, store and classify data on GBV incidents. IRC is one of five agencies sharing data with the GBVIMS.

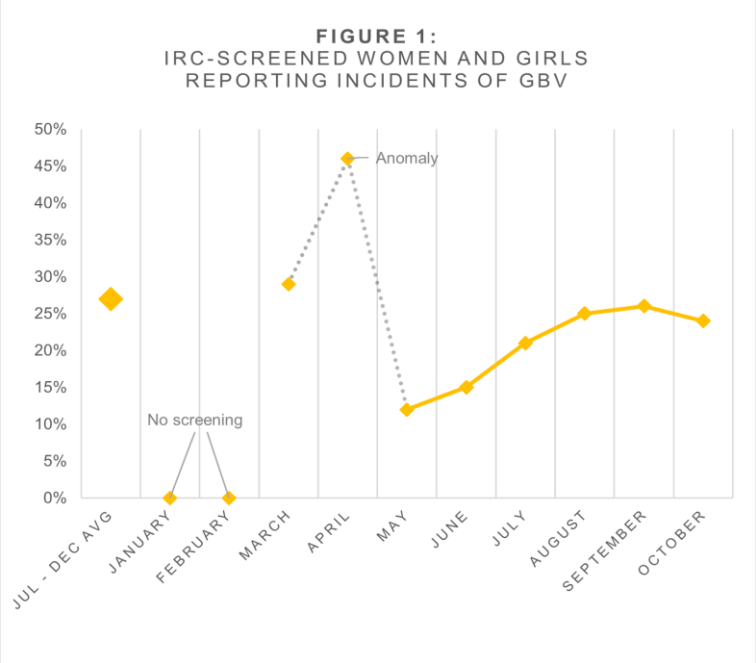
I. IRC GBV screening data, January 2020 - October 2020

IRC data shows that an average of one in four women and girls[2] screened reported incidents of GBV (consistent with the findings of IRC's July - December 2019 data). As stated in the 2020 Joint Response Plan, given the barriers to reporting in Cox's Bazar, "the recorded cases are likely to represent only a small fraction of the overall number" (JRP II). The impact of the COVID response further supports the trend of under-reporting of GBV.

Following the onset of COVID-19 mitigation measures from March 2020 onwards, the presence of protection partners in the camps was significantly reduced. The Protection Cluster reported that the reduction led to a decrease in the Rohingya community's trust of, and outreach to, protection actors. The Joint Response Plan Mid-Term Review notes that the "limited number of protection actors in the camps resulted in a vacuum in conflict, mediation and legal services" and expressed concerns about "an evident increase in gender-based violence, child marriage, and insecurity in the camps" as a result (JRP). IRC staff note that during these first months, **the decision by the Government of Bangladesh to suspend GBV prevention activities such as Girl Shine,[3] EMAP[4] and SASA![5] had a clear and significant impact on community awareness of GBV, and consequently on levels of reporting in the camps.**

Despite the constraints from COVID-19 and reductions in protection staff, IRC screening data continues to show that on average, at least 25 percent of women and girls report they are survivors of GBV. The fact that the average rate of GBV reports did not drop during this time of significantly exacerbated barriers to reporting indicates there was likely a rise in violence against women and girls during the pandemic. The Joint Response Plan Mid-Term Review reached similar conclusions, stating that "while formal GBV reports have declined, anecdotal evidence indicates that incidents are on the rise, as is the severity of incidents reported." (JRP)

Figure 1 shows the total percentages of women and girls screened by IRC staff who reported incidents of GBV in the first ten months of 2020.



Explaining the data anomaly in Figure 1: In April, a combination of factors led to a significant reduction in women and girls being screened for GBV, distorting the data for positive cases: reduced mobility in the camps as a result of lockdown, the suspension of GBV prevention activities, an overall reduction in access to GBV services, fear of contracting COVID-19 at health centres, and fear of being forcibly quarantined at health centres. In addition, women and girls were "reportedly refraining from seeking medical services in reproductive health clinics due to fears associated with being identified as or having been exposed to COVID-19 patients" (JRP). As a result, the April spike in Figure 1 should be interpreted as a distortion in data reflecting the overall low numbers of women and girls reporting incidents yet high proportion of positive cases. Noting this data distortion, we would still expect reported GBV rates in April to be at least as high as rates in March or May, when the same conditions in the camps persisted. This position is supported by additional sources which suggest that GBV prevalence at this time was likely significantly higher than the screening data indicates. For example, IRC's Key Informant Interviews conducted in July found that 90 percent of Rohingya interviewees reported increased rates of IPV during the first months of COVID-19 in Cox's Bazar. In addition, the GBVIMS screening data – analysed in Section II – also indicates spikes in physical assault during the month of April. Finally, the Joint Response Plan Mid-Term Review notes an "increase in sexual and gender-based violence" (JRP) from early April.

[2] Reported numbers of GBV do not capture the entirety of violence against women and girls. Stigma, fear, isolation, and the threat of being killed often prevent women and girls from seeking services after an incident of GBV which leads to underreporting. The actual number is higher.

[3] Girl Shine is an adaptable programme model developed by IRC to support, protect, and empower girls in fragile and conflict-affected settings by providing them with the skills and knowledge to recognise different types of GBV and seek support services if they or someone else is at risk.

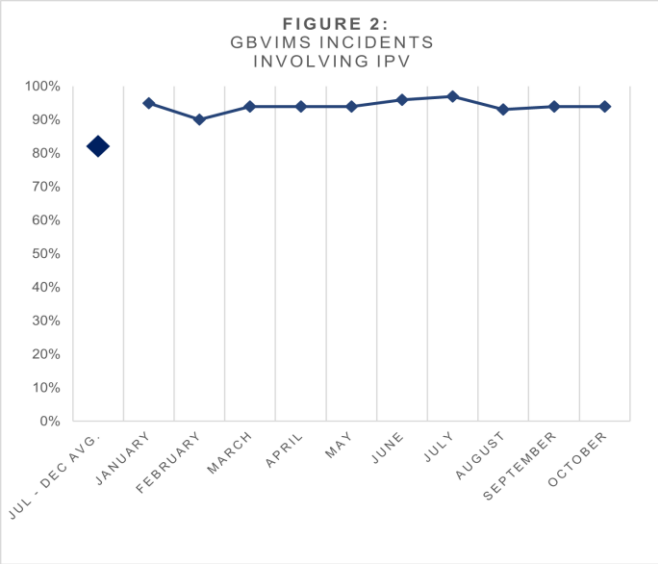
[4] Engaging Men through Accountable Practice (EMAP) is an IRC-led GBV prevention initiative developed for humanitarian settings which uses an evidence-based curriculum to engage men in transformative behaviour change, guided by women.

[5] SASA! is a community-led approach to GBV prevention run by the organisation Raising Voices which addresses the power imbalances between men and women through building a positive understanding of gender equality.

II. Trends in GBVIMS case management data, January 2020 - October 2020

IRC has also analysed trends in GBVIMS case management data, finding that **an average of 94 percent of recorded GBV incidents were perpetrated by intimate partners,[6] higher than the 81 percent average indicated by the 2019 GBVIMS data in IRC's June *Shadow Pandemic* report.**[7] Data supports the concern that the onset of lockdown in March contributed to rising levels of IPV as a result of GBV survivors being trapped in domestic settings with their abusers. This trend is again further supported by other data sources.

Data from IRC's KIIs conducted in July 2020 shows that 90 percent of participants reported an increase in IPV, while 60 percent reported increased sexual violence and harassment when accessing services. These findings are in line with international data, including IRC analysis of displacement and conflict settings which found that 73 percent of women reported that IPV had increased in their communities (IRC).



In addition, the Joint Response Plan Mid-Term Review notes that during this time, "the closure of community facilities, learning centres and other safe spaces, and the limited access to livelihoods[8] and vocational skills training opportunities has led to increased violence in the home for women and children" (JRP). IRC interviews with Rohingya refugees support this finding. Female Rohingya respondents note that men spent more time at home as a result of the loss of livelihoods during lockdown, thereby increasing the likelihood of IPV incidents. In addition, lockdown also left women and girls with less overall mobility, and with male IPV perpetrators at home more often, they were less able to safely and discreetly access Women and Girls Safe Spaces (WGSS) to report incidents or to receive support.

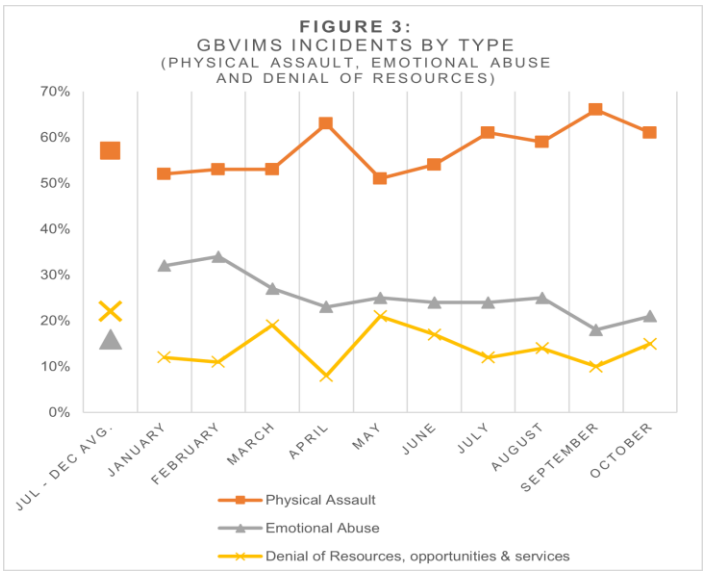
The concern of higher levels of IPV as a result of a loss of livelihoods is consistent with IRC's assessment from the June *Shadow Pandemic* report that male loss of status and unfulfilled expectations over traditional domestic roles can exacerbate the already known risk of male violence in domestic settings.

IRC interviews with Rohingya women and girls also suggested that there has been an overall lack of male engagement in GBV sensitisation programming, likely contributing to the difficulty in confronting high IPV rates. These findings further emphasise the importance of continuing GBV prevention activities even during lockdown, and where necessary modifying interventions to, for example, accommodate social distancing.

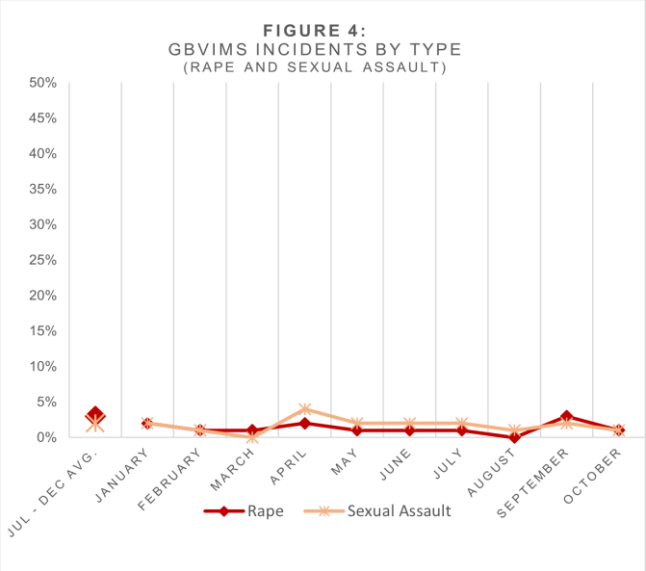
Physical assault is the primary *type* of GBV recorded in the GBVIMS 2020 data, with rates significantly spiking first in April (the month following the onset of lockdown, suggesting a rise in reporting as a result of IPV) and then again in September (one month after prevention activities had restarted, suggesting a clear link between availability of services and increased reporting of GBV incidents).

Physical assault and emotional abuse, the two most common types of GBV recorded in this dataset, are often perpetrated by intimate partners. High levels in this time period are likely related in part to confinement to domestic settings under lockdown. An overall reduction in the presence of humanitarian workers, a lack of male GBV sensitisation programming, and a simultaneous decrease in the number of police patrols, may have further contributed to an environment which emboldens physical abusers at home and criminal activity in public.

Physical assault was also the most common form of GBV reported among Rohingya in IRC's 2019 screening data, which Women's Protection and Empowerment (WPE) caseworkers indicate is often happening in the context of IPV. While physical assault reporting saw a drop following its peak in April, it has since been on an upwards trend. This may be explained by the increasing availability of prevention activities as COVID-19 lockdown has eased, which include a focus on awareness raising around what constitutes GBV and when to access services.



6 Intimate Partner Violence (IPV) is a form of domestic violence which consists of, but is not limited to, physical and sexual abuse, emotional violence, and denial of resources, therefore is represented in a different graph to other forms of GBV.
7 Given that the GBVIMS database contains data on women and girls who are receiving case management, a service typically for serious and ongoing issues, IPV tends to be highly represented in the data. However, even higher levels in this time as compared to the July - December 2019 average indicate that rates of IPV are indeed rising.
8 The Government of Bangladesh does not permit Rohingya to engage in paid employment; however, informal income-generating activities such as selling goods or manual labour occur across the camps, in addition to daily wages being paid to volunteers for humanitarian actors.



Reported levels of rape and sexual assault are low, but it is known to be the most under-reported type of GBV within the community.

According to IRC interviews conducted in July 2020, women and girls report facing higher risks of sexual assault while accessing WASH facilities or other basic needs, e.g. at food distribution points, water collection points, and toilets. Interviewees also reported behaviour which amounts to sexual harassment, known colloquially as "eve-teasing", while waiting in line for water or food collection points, and stated that certain paths towards collection points are unsafe for adolescent girls due to the risk of sexual assault by male community members.

Rape and sexual assault carry the highest risks of reprisal for reporting due to the seriousness of these types of GBV and potential criminal consequences. They also carry greater social and cultural stigma for the survivors, which represents a psychological barrier to reporting incidents, or even to consenting to screening. Taken together, this indicates that actual incidence of sexual harassment and assault are likely much higher than the GBVIMS data suggests.

Recommendations

1) **The gender hub and GBV sub-sector** should press for the Refugee Relief and Repatriation Commissioner (RRRC) to designate all critical GBV response services as essential (including Clinical Care for Sexual Assault Survivors, psychosocial support, and group sessions) to allow for continuity of GBV services and information provision throughout the remainder of the COVID-19 response, in light of data suggesting an increase in prevalence while GBV services are unavailable. Implementing agencies should increase their focus on encouraging men and boys to engage in prevention activities.

2) **International donors and the UN** should encourage the Government of Bangladesh to consider facilitating access to economic self-reliance opportunities for women, men, boys, and girls to tackle high levels of IPV.

3) **International donors** should ensure funding for the GBV response is prioritised in donor strategies for 2021. The significant funding gaps under the 2020 response - less than one-fifth of required funding for GBV programming was reached under the 2020 JRP - should be addressed and funding levels increased to ensure the continuation and expansion of life-saving GBV programming.

4) **All actors involved in the response** should mitigate the risk for GBV by addressing site management issues, including prioritising gender-responsive and gender-specific WASH services for women and girls, improving overall levels of lighting, while ensuring that communal spaces are safe and well-monitored during periods of more significant COVID-19 mitigation measures, with progress regularly monitored by the UN and sector lead agencies.

5) **The UN, Government of Bangladesh, donors and implementing agencies** should continue to work towards the delivery of a comprehensive service package for survivors of GBV, including support related to sexual and reproductive health, mental health, psychosocial support, security, legal services and justice, and self-reliance.

6) **International donors** should work with implementing agencies, the Government of Bangladesh and UN agencies to agree a strategy for the localisation of the Rohingya GBV response, with realistic timeframes and appropriate multi-year funding, employing the expertise of INGOs to support national capacity and handover programming to national NGOs and women-led organisations working in their communities, in a way that avoids any gaps in managerial and technical capacity and ensures Interagency Standing Committee (IASC) standards are met.