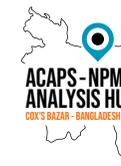


BANGLADESH

Needs and priorities of Rohingya refugees and host communities in Cox's Bazar since 2017: what has changed?



Thematic report
30 August 2022

OVERVIEW

August 2017 and the months that followed saw the influx of more than 700,000 Rohingya refugees fleeing violence in Myanmar's Rakhine state to Cox's Bazar, Bangladesh. This influx brought the Rohingya refugee population in Cox's Bazar to over 900,000 (IOM 31/03/2022). While there has been continuous humanitarian support for the refugees, restrictions imposed in response to COVID-19 interrupted some humanitarian activities and forced the scaling down of others. Humanitarian activities had fully resumed by mid-2021, but the negative impacts of COVID-19 restrictions persist (ISCG 04/11/2021).

Since 2017, the refugees' prioritisation of their needs has changed. In the first months after arriving in Cox's Bazar, the focus was almost entirely on basic needs, such as food, water, shelter, and safety and security. As the situation stabilised, income-generating activities and education became increasingly important. The effect of COVID-19 and increased government restrictions that reduced livelihood opportunities and access to education reinforced the prioritisation of these needs for the Rohingya. For people living in host communities, there is a similar trend regarding priority needs.

About this report

This report provides an overview of how the reported needs and priorities of both Rohingya and host communities have evolved since 2018, when the first major assessments were carried out. The comparisons here were mainly based on two annual representative assessments, the Joint Multi-Sector Needs Assessment (J-MSNA) and the Refugee Influx Emergency Vulnerability Assessment (REVA). The analysis also includes other reports and studies where relevant to complement these comparisons and should be considered alongside other existing information on how Rohingya and host community needs have changed over time with some indications of the current situation where possible.

We are extremely grateful to all the organizations working in Cox's Bazar for sharing documents, answering questions and reviewing this report.

The question this review aimed to answer was:

“ How have living conditions and the humanitarian situation for the Rohingya and host communities in Teknaf and Ukhia changed over time? ”

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KEY MESSAGES

Food remains a priority need despite the presence of food assistance. The food consumption situation was stable for the two years before COVID-19, with 56% (2018) and 58% (2019) of the population having an acceptable food consumption score (FCS). Changes in the frequency and modality of food assistance, combined with the increased susceptibility of food assistance to market prices, saw a decline in the FCS of households in both Rohingya and host communities during the pandemic. There are indications that the FCS began to recover in 2021, although 45% of the Rohingya population still had an unacceptable FCS. Overall, the FCS of the host community declined during the pandemic. Overall, the FCS of the host community declined during the pandemic. As at 31 December 2021 it had yet to recover, with 62% of households (compared to 70% in 2018 and 79% in 2019) having an acceptable FCS.

Female-headed households (FHH) in host communities continue to suffer more from inadequate diets than in the Rohingya community.

Livelihoods: lockdown restrictions in response to COVID-19 reduced livelihood options for both communities. Even upon the lifting of these restrictions, income-generating options have remained limited. Reduced livelihood opportunities have increased the use of emergency coping strategies for both communities. The lack of income sources has increased the reliance of host community members on humanitarian assistance, while the Rohingya community has continually depended on it. Host community members also tend to more frequently adopt food-related coping strategies to cover the cost of other necessities.

Healthcare: Rohingya refugees have consistently preferred to seek health assistance from NGO-run clinics. Their overall dissatisfaction with health services increased during the pandemic. According to them, the main barriers to accessing medical treatment have changed from the unavailability of medicine and supplies at the beginning of the response to the overcrowding of facilities. The host community has expressed similar issues, and for them, the distance to health facilities is also an obstacle.

Shelter materials continue to be a priority need in the camps, as government restrictions require people to construct shelters from non-durable materials (bamboo and tarpaulins). These building materials degrade quickly and are susceptible to damage by the elements. The shift from firewood to liquefied petroleum gas (LPG) as cooking fuel has significantly reduced health, safety, and protection concerns and environmental degradation. The lack of lighting in the camps, however, remains a key concern.

Water quality and availability in the camps have improved. Despite the increased number of water points overall, access remains an issue in some specific locations. The lack of maintenance of WASH facilities during the COVID-19 pandemic has worsened the situation.

The availability of soap has increased, but menstrual hygiene items have been reported insufficient and inconsistently supplied for Rohingya refugee women throughout the response.

Gender-based violence (GBV) and child protection: COVID-19 containment measures aggravated incidences of GBV and child protection concerns, such as kidnapping and involvement in drug trafficking. The restrictions also forced the closure of protection services by humanitarian organisations in the camps until late 2021. Informing Rohingya refugees about these services and encouraging trust in them have been a challenge, and the closures during this time further limited their understanding of the protection services available. The situation led them to continue seeking assistance from Majhis and the Camp in Charge (CiC) instead of humanitarian organisations.

Education: access to education has improved but remains difficult for some Rohingya children, particularly older children. UNICEF and its partners launched the Myanmar Curriculum Pilot in November 2021. This programme is expected to improve the quality of education in camps. The education of host community children has suffered across the response for a range of reasons, including the use of educational facilities for other purposes (such as temporary shelters for newly arrived refugees and temporary camps for law enforcement institutions). School closures and the challenges of implementing remote learning in both communities during the pandemic reduced education access in 2020–2021.

Nutrition: the prevalence of global acute malnutrition (GAM) among both Rohingya and host community children improved in 2018–2019 as the programme coverage increased but slightly deteriorated as services scaled down during the COVID-19 pandemic. Dissatisfaction with nutritional services rose during the pandemic.

Communication with communities improved in 2018–2019 but there was limited face-to-face contact during the pandemic. This restriction severely reduced public health messaging and communication designed to enable people to make informed decisions. Consequently, the number of families reporting confidence that the humanitarian community considered their opinions significantly decreased.

CRISIS AND RESPONSE DEVELOPMENTS SINCE AUGUST 2017

Bangladesh has received successive waves of Rohingya refugees since 1978. Before August 2017 and after bilateral negotiations in 1992 and the signing of a memorandum of understanding in 1993, most refugees had returned to Myanmar, leaving approximately 33,000 in registered camps and an unknown number, estimated to be between 200,000–500,000, in informal settlements or host communities in Cox's Bazar (MSF 21/08/2020; ACAPS 11/12/2017). The ethnic cleansing in Rakhine state in August 2017 caused more than 700,000 Rohingya to flee to Bangladesh within a few weeks (OHCHR 11/09/2017). They remain in Cox's Bazar, except for

around 26,000 who were moved to Bhasan Char, an island in the Bay of Bengal developed to house the refugees (UNHCR 12/07/2022).

Rohingya refugees in Cox's Bazar: key developments from August 2017 to 2022

August–December 2017: influx

Upon arrival in 2017, the Rohingya settled in makeshift camps in previously forested hills of Cox's Bazar close to the border with Myanmar. The host community initially welcomed and supported these refugees. In the first months of the crisis, the refugees focused on survival. Host communities and the Government of Bangladesh provided important initial humanitarian assistance.

December 2017 to November 2018: setting up the 'megacamp', establishing the government coordination structure, and ramping up international humanitarian response

In 2018, the UN and the Government of Bangladesh began to move families to camps within a megacamp area set up at Kutupalong Balukhali in the upazila of Ukha. The Government established the organisational structure for the camps. This system, under the authority of the Refugee, Relief and Repatriation Commissioner, includes the CiC structure and has the overall responsibility for administration, service delivery, and coordination with Majhis and humanitarian responders in the camps (ACAPS 11/06/2018). During this period, the enormity of the challenge of hosting so many refugees became more evident and pushed international and local organisations to step up efforts (Ansar and Md. Khaled 09/07/2021).

November 2018: emerging tensions with the host community and implementation of movement restrictions for the Rohingya community over time

After a failed attempt to repatriate the refugees, and as resources, such as forests, water, and livelihood opportunities, became scarcer, tensions between Rohingya refugees and Bangladeshi host communities began to grow (UNDP 27/07/2019; Ansar and Md. Khaled 09/07/2021). The Government's response was to place increasing restrictions on the Rohingya's movement and right to work (BBC 16/09/2017; APHR 06/03/2018). Perceptions of the host community that the Government and humanitarian responders were not recognising the negative impact of the refugee influx on Bangladeshis further undermined their relationships with refugees (Ansar and Md. Khaled 09/07/2021). While the humanitarian response continued to provide essential support across the sectors, there was increased focus on supporting livelihoods and protection services. By the third year of the response (late 2019 to 2020), concerns regarding

inter- and intra-community issues (such as kidnapping, human trafficking, rape, issues with land usage, and access to markets) increased (ACAPS 20/12/2019). In late 2019, the Government of Bangladesh started building a barbed wire fence around the camps to restrict the movement of the Rohingya (The Daily Star 24/11/2019).

Mid-2020 to late 2021: the challenges of COVID-19 restrictions

By mid-2020, the COVID-19 pandemic had reached the camps. Responding to it included imposing severe movement restrictions on refugees and humanitarians, reducing humanitarian presence in the camps to only essential and life-saving humanitarian assistance (ACAPS 07/07/2020; BBC Media Action/TWB 20/05/2020). Rohingya refugees were primarily concerned about contracting COVID-19, the deteriorating conditions across sectors, and the restrictions on their movement. In the host community, the pandemic measures disrupted economic activities and increased the need for support (ISCG et al. 22/07/2020).

On 23 March 2020, strict lockdown measures were imposed in Rohingya camps aligning with the instruction of the Government of Bangladesh allowing only essential services to continue (RRRC 24/03/2020). These restrictions were gradually lifted from July 2020 (iMMAP 31/07/2021). With the number of COVID-19 cases rising sharply daily, a second strict lockdown started on 5 April 2021 and then was lifted on 9 September, with the exception of educational facilities (RRRC 05/04/2021 and RRRRC 09/09/2021). From late 2021, the fourth year of the response, the situation began to stabilise, and the slow resumption of humanitarian activities began.

December 2020 to 2021: transfers to Bhasan Char and the signing of a memorandum of understanding by the UN agreeing to provide services in the island

In 2020, the transfer of Rohingya refugees to Bhasan Char, a previously uninhabited island in the Bay of Bengal about 60km from the mainland, began. The relocation claimed to provide better living conditions to refugee families than in the overcrowded camps (New Age 03/12/2020). In October 2021, the UN and the Government of Bangladesh signed a memorandum of understanding that the UN would collaborate with the Government in providing services to Rohingya refugees residing in the island (UN 09/10/2021). The plan was to transfer 100,000 refugees to the island (HRW 07/06/2021). As at February 2022, only over 20,000 refugees had been relocated to Bhasan Char (UNHCR 24/03/2022).

February 2021: coup in Myanmar

With the military coup in Myanmar in February 2021 and the ensuing civil war, repatriation negotiations between Bangladesh and Myanmar became less likely, increasing the need for durable solutions (ICG 01/06/2022). The Rohingya's prospective return to Myanmar in 2022 appeared unlikely.

Late 2021: deterioration of security in the camps

Since late 2021, general security conditions have deteriorated in the Rohingya camps. An armed organisation active across the camps murdered a prominent Rohingya leader on 29 September 2021 (Al Jazeera 16/03/2022). Another attack occurred on a madrasa in October 2021, killing six teachers and students (The Daily Star 23/10/2021). As a result, the sense of insecurity in the camps has increased. The Government of Bangladesh has placed tighter restrictions on the mobility of the Rohingya within the camps (HRW 04/04/2022).

METHODOLOGY

This report used the secondary data review of reports from two large and representative assessments – the J-MSNA and the REVA – carried out annually to investigate how the humanitarian needs and priorities of Rohingya refugees and the Bangladeshi host community in Cox's Bazar have evolved since 2018.

Differences in survey questions, sample size, and assessment approaches made comparisons over time and identifying changes from these assessments challenging. It is natural to learn lessons from assessment experiences and employ these lessons to create better questions and overall improved assessments. A consequence, however, can be that unless comparison over time is intentionally considered, a better assessment for one year can reduce overall comparability, as is the case in the Rohingya response (ACAPS 25/11/2021). Although the assessments generally considered the same indicators (see Annex 2), analysis took place using different tools and approaches.

One of the two annual large-scale assessments in the Rohingya response used was the J-MSNA (referred to as the MSNA in 2018), which had taken place under the coordination structure of the Inter-Sector Coordination Group (ISCG) for Rohingya Refugees in 2018, 2019, 2020, and 2021, and for Bangladeshi residents of the upazilas of Teknaf and Ukhia (also referred to as host communities) in 2018, 2019, 2020, and 2021. The other was the WFP-led REVA (2017, 2018, 2019, 2020, and 2021), which included Rohingya and host populations (Ukhia and Teknaf). Throughout this report, the REVA and MSNA/J-MSNA reports are referenced by the abbreviated report name and the year to which the data refers, not by the lead body that published the report

and the date of publication – e.g. the report references the ISCG-led report on the Rohingya refugees published in 2021 as J-MSNA Rohingya 2020 (with hyperlink). Reviewing the J-MSNA and REVA questionnaires along with the corresponding reports led to the creation of a list of the indicators that could be compared over time.

To mitigate some of the inconsistencies in the questions used over time, fill other information gaps, and triangulate analysis results, additional information from sector assessments, other secondary data, and consultations with partners, such as IOM's Needs and Population Monitoring unit, supplemented the elaboration of some of the comparable indicators in the list where possible.

The findings were shared twice with sector working groups and humanitarian responders. Where it was within the scope, their feedback was incorporated into this report. ACAPS tried to maintain the focus on understanding the evolution of humanitarian needs through the representative assessments and avoided including additional information that strayed too far from the indicators addressed in these assessments. Exceptions were made in the education and protection sectors, where the lack of comparable indicators over time in the J-MSNAs is particularly evident. Without the additional information, there would have been little to say about these sectors in this report.

Limitations

Although one objective of regular J-MSNAs is “to facilitate an understanding of the evolution of needs and service gaps across time”, as stated in the 2020 and 2021 J-MSNA reports, the questionnaires used were not consistent over the years. The inconsistencies limit the comparability and result in the exclusion of many questions that otherwise would have been useful for assessing change.

In 2020–2021, COVID-19 restrictions led to the remote collection of J-MSNA data through phone interviews, making the approach significantly different from previous years. Some indicators were not directly comparable between host and refugee populations, as different data geared towards their specific context was collected for the two communities, making direct comparisons between the two groups difficult.

Changes to the assessment including questionnaire design in these assessments are to be expected. Staff members change from year to year, meaning sometimes, the annual assessment does not benefit from the institutional memory of the one before. At the same time, a constant effort to improve the assessment based on lessons learnt can effect changes in the process and questions asked. While the changes can result in a better snapshot of the situation at the time, they can also limit comparability with previous assessments, as is the case in the Rohingya response – something stakeholders should consider moving forward.

SECTOR TRENDS: CHANGES REPORTED IN THE ASSESSMENTS OVER TIME

Food security and livelihoods

Food security

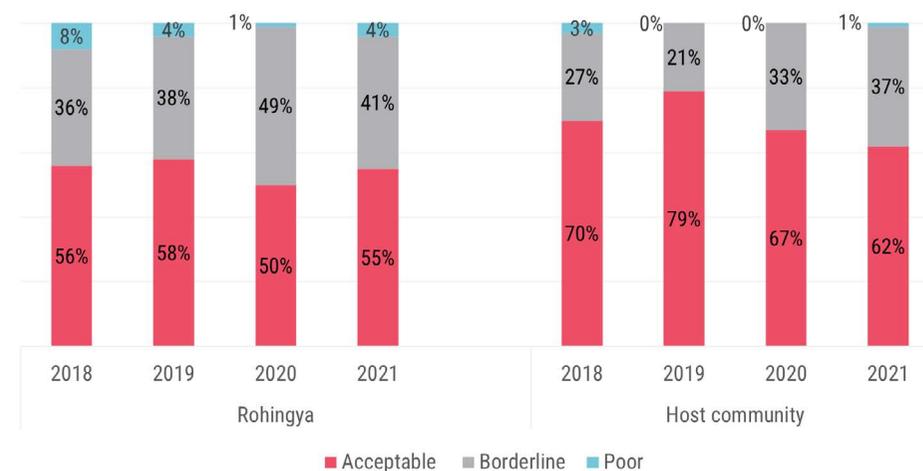
The food consumption situation was stable for the two years before COVID-19, with 56% (2018) and 58% (2019) of the camp population having an acceptable FCS.

Humanitarian food support continued during the pandemic, but containment measures, market closures, price increases, and restrictions on economic activity drove a slight deterioration of the FCS in the camps. There are indications that the FCS began to recover in 2021, although 45% of the population still had an unacceptable FCS. Humanitarian assistance has likely been benefiting the food consumption situation of the host community since 2018.

There appeared to be a higher prevalence of unacceptable diets in FHHs in the host community than in Rohingya refugee camps. Overall, the FCS of the host community declined during the pandemic. It has yet to recover.

The introduction of e-vouchers in 2019 reversed a decline in the FCS of the Rohingya population until COVID-19 restrictions negated the gains. Rohingya refugees have been receiving food assistance since their arrival in 2017. Initially, some of the Rohingya used their assets to meet food needs, but as they depleted these assets, the refugees became fully dependent on assistance. As a result, the percentage of those with an acceptable FCS dropped by more than 10% in 2018 and remained at these levels throughout the following year (REVA 2017, 2018, and 2019).

Figure 1. Food consumption scores of Rohingya refugees.



Sources: REVA (2018, 2019, 2020, and 2021)

In 2019, the mode of food assistance changed from in-kind support to e-vouchers, increasing refugees' choices over the type of food and the frequency at which they purchased supplies. The e-voucher system is likely the reason behind the improved refugee FCS.

In 2020, COVID-19 restrictions limited humanitarian access to camps. Though the e-voucher system continued, there was a shift from value vouchers to commodity vouchers, with commodity vouchers offering less flexibility given the fixed quantity and quality of specified goods offered during the pandemic (Socialprotection.org accessed 23/08/2022; REVA 2019). The frequency at which the refugees received these vouchers also changed from twice to once a month, leading to food wastage from expiration and higher transportation costs (ACAPS/IOM 28/04/2021). At the same time, pandemic-related restrictions closed down fresh food corners and markets, limiting access to fresh food, increasing prices, and restricting income-generating activities. These factors contributed to an increase in the percentage of people with borderline FCS in 2020 (see figure 1).

In 2021, the food consumption situation recovered slightly, with 55% of refugees having acceptable scores and 41% having borderline scores, but remained worse than pre-pandemic (REVA 01/2022).

The provision of targeted humanitarian assistance had a positive impact on the FCS of the host community, but measures put in place to address COVID-19 also affected their food consumption. Their FCS remained stable between 2017–2018 (see figure 2), with 70% of the population having acceptable scores and 27% having borderline scores. The situation improved in 2019, with almost 10% more households having an acceptable FCS.

In 2020, COVID-19 restrictions, associated market price increases, and a 47% drop in the income of wage workers reversed these gains and led to a significant drop in the proportion of households with an acceptable diet (WB 07/2020). These developments pushed the FCS of approximately 12% of households from acceptable to borderline (REVA 2019 and 2020). In 2021, any recovery of livelihoods from the pandemic had yet to have a noticeable impact on people's FCS. Instead, reduced purchasing power and continued food price increases further decreased the proportion of households with acceptable food consumption scores to 62%, while 37% had borderline scores (FAO/WFP 31/12/2021; REVA 01/2022).

Over the years, FHHs have generally struggled with access more than male-headed households. Throughout 2017–2018, FHHs within both Rohingya and host communities were less likely to have an acceptable diet than male-headed households (REVA 2017 and 2018). In 2019, the REVA found no significant differences in food consumption between male- and female-headed households among the Rohingya refugees, although J-MSNA data suggested the disparity persisted (REVA 2019; J-MSNA Rohingya 2019).

In 2020, COVID-19 and accompanying containment and risk mitigation measures resulted in households without a working-age male member being more likely to report having lost access to basic services (J-MSNA Rohingya 2020). These households have access to fewer income-generating opportunities and self-reliance activities, and the increased vulnerability is likely linked to the challenges in acquiring and transporting assistance without the help of an adult man. As the frequency of humanitarian distributions decreased, the consequent increase in the size and weight of distributed packages resulted in many recipients selling a proportion to pay portorage (ACAPS/IOM 28/04/2021). Free porter services were arranged for households identified as extremely vulnerable (such as the elderly, pregnant women, people with disabilities, and COVID-19 suspected cases). The problem for some households, notably those comprising an elderly person and only young female members, was they were not listed as extremely vulnerable given the presence of a younger member at working age (IOM 17/06/2021; ACAPS/IOM 28/04/2021). With the easing of COVID-19 restrictions and reopening of markets, the food consumption situation is expected to improve. In 2021, male- and female-headed households were observed to have a similar FCS (REVA 01/2022).

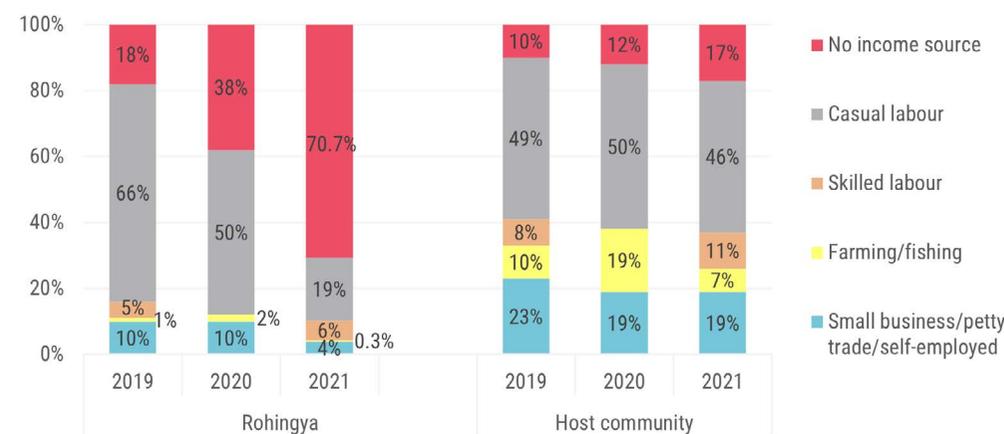
In the host community, the proportion of FHHs with an unacceptable FCS has been

consistently higher than that of male-headed households. In 2017, 38% of FHHs had an unacceptable FCS compared to 27% of male-headed households (REVA 2017). Throughout the following years, FHHs, households with a high dependency ratio, and households with one person aged five or older who needed daily support consistently continued becoming more vulnerable to food insecurity (REVA 2018 and 2019; J-MSNA Host 2019 and 2020; ACAPS 04/10/2020). In 2021, more FHHs (48%) were found to have inadequate food consumption than male-headed households (36%) (REVA 01/2022). This proportion is different from the Rohingya community, where food assistance covers both male- and female-headed households more equally. In the host community, men had better access to the local labour market than women, enabling them to access better food supplies.

Livelihoods

Livelihood opportunities available to the Rohingya and host populations differ significantly, as the Government restricts work opportunities for refugees, officially preventing them from accessing formal employment. While the host population almost entirely depends on employment or other income-generating activities, the Rohingya community primarily depends on humanitarian assistance as their primary income source. Of the Rohingya earning income 75–80% were primarily engaged in casual work, the least secure type of income source. By contrast, almost all host community households had an adult engaged in income-generating activities. Of this number, just over half (53–58%) relied on casual labour as their primary income source (REVA 2017, 2018, 2019, 2020, and 01/2022). The primary income sources of Rohingya and host community over time are given in figure 2.

Figure 2. Main sources of income (excluding humanitarian assistance).



Note: data for 2017 and 2018 was omitted because of incomparability.

Sources: REVA (2017, 2018, 2019, 2020, and 2021)

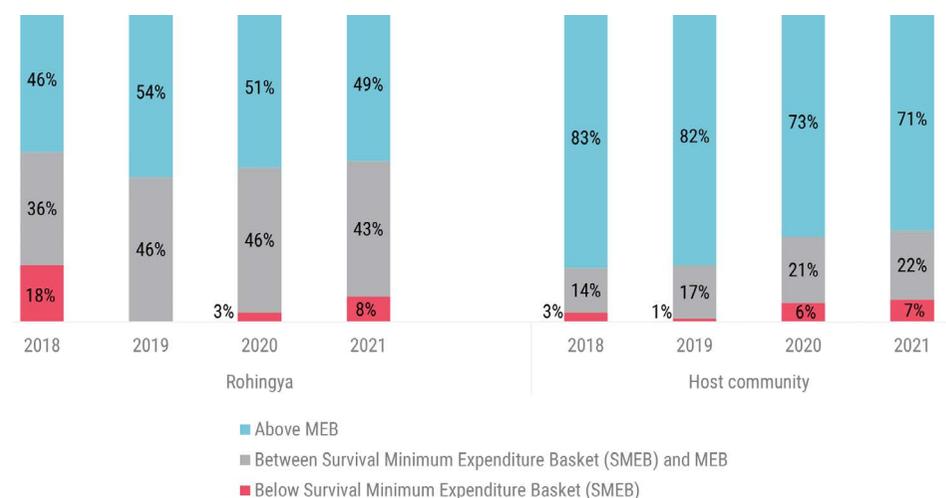
In 2018, more than half of the respondents in the Rohingya J-MSNA reported having no working adult in the household (J-MSNA Rohingya 2018). The limited livelihood opportunities encouraged refugees to adopt more negative coping mechanisms to fulfil their needs. While the REVA in 2019 found that 80% of Rohingya households had some form of income, most were in casual labour with very low income. Another study found that 45% of households reported no income and depended entirely on aid and coping mechanisms to meet their basic needs (The Asia Foundation/CPJ 09/09/2020). During the pandemic years of 2020–2021, the number of Rohingya households with a working adult sharply fell, while the average income of a casual labourer was significantly less than half of those in the host community (REVA 2019, 2020, and 01/2022). One illustration of this is the increased proportion of people unable to afford the Survival Minimum Expenditure Basket (SMEB). During the pandemic years there was also an increase in the proportion of the host community unable to afford the SMEB as shown in figure 3.

COVID-19 restrictions reduced livelihood options for both communities. Information collected throughout the COVID-19 response consistently showed that the loss of livelihood activities and income sources was the most pressing concern for Rohingya refugees (WFP 10/06/2020; IOM 20/09/2020; BBC Media Action/TWB 17/09/2020; ACAPS/IOM 04/2020 and 25/08/2020). In 2020, the pandemic disrupted certain income-generating activities, such as volunteering for NGOs, participating in cash-for-work programmes, and receiving cash incentives for skill development training sessions. On the other hand, humanitarian responders quickly set up other income-generating programmes specific to the pandemic situation, such as mask production. By October 2020, humanitarians had employed over 2,480 individuals from both Rohingya and host communities; they produced over 2.5 million masks since April 2020 (ISCG 21/10/2020). Despite the adjustment, containment measures resulted in a 64% drop in employment, leaving households with less finances and making them more reliant on negative coping mechanisms to fulfil basic needs not covered by humanitarian assistance (WB 07/2020). The pandemic also appeared to reduce remittance flows, which an estimated 20% of households reported receiving pre-pandemic (The Asia Foundation/CPJ 09/09/2020).

The economic situation of the host community population was relatively stable in 2018–2019 but worsened during and since the pandemic, likely because of the COVID-19 mitigation measures that restricted people from working (REVA 2020). Overall vulnerability, which the WFP defines as a combination of the ability of a household to meet essential needs, the coping strategies they adopt, and their food security status, increased for both Rohingya and host communities in 2020, as shown in figure 4 (REVA 01/2022).

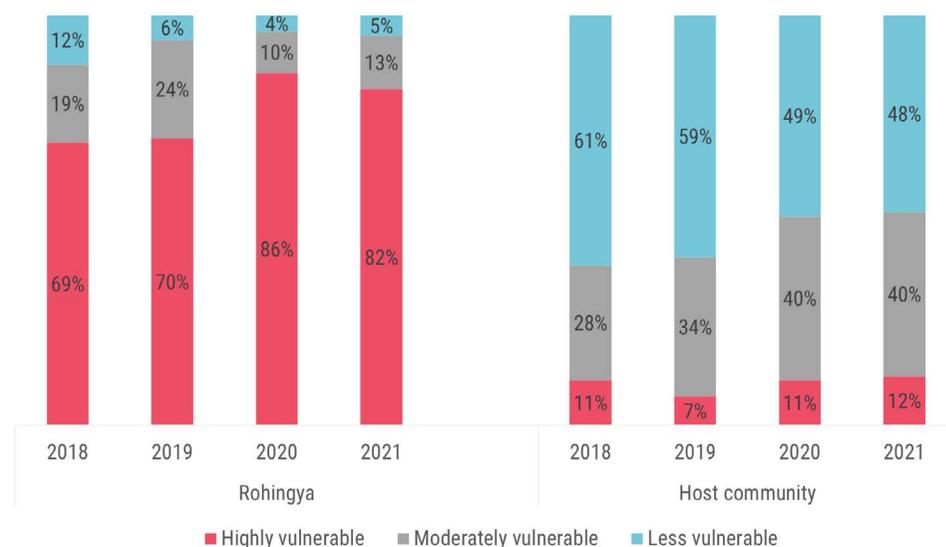
Remittances play an important role in economic support among the Rohingya. In 2017, those receiving remittances were found to be less poor and had a 16% lower rate of unacceptable FCS. From 2017–2020, the percentage of the Rohingya receiving remittances decreased from 4% to 1% before increasing to 6% in 2021. Likewise, the percentage of the host population receiving remittances decreased from 7% to 1% until 2020 before increasing to 5% in 2021 (REVA 2017, 2019, and 01/2022).

Figure 3. Changes in the economic vulnerability levels of Rohingya and host communities.



Source: REVA (01/2022)

Figure 4. Changes in the overall vulnerability levels of Rohingya and host communities.



Source: REVA (2021)

Health

The health-seeking behaviour of refugees varied in the reporting period from 2017–2021, with a slight decrease in the percentage of people seeking treatment in NGO-run clinics in 2020 compared to previous years.

The main barriers expressed by Rohingyas to accessing medical treatment changed from the unavailability of medicine and supplies at the beginning of the response to the overcrowding of facilities in 2021. The host community faced similar barriers, with an additional significant barrier being the distance to health facilities.

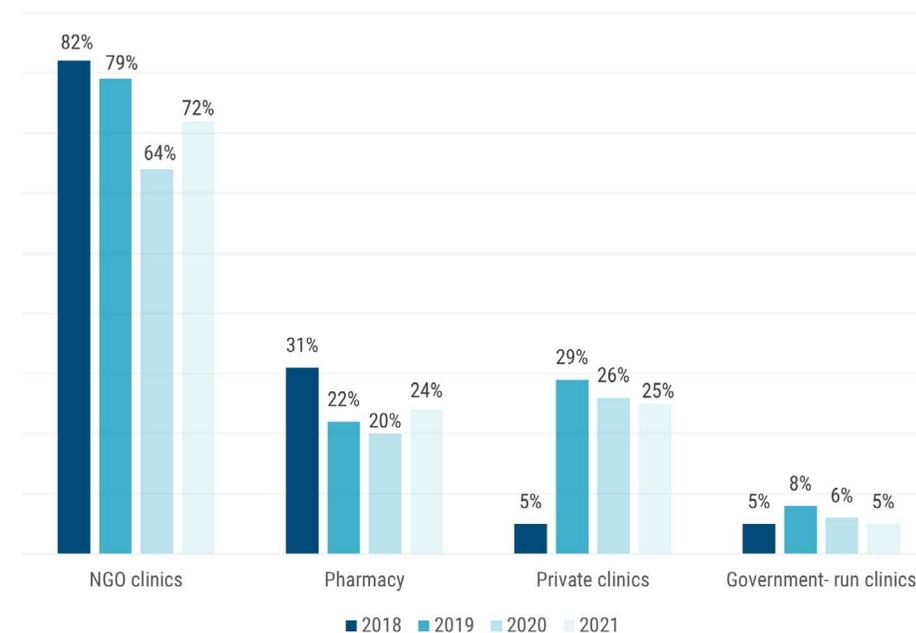
Other factors for the reluctance of the Rohingya communities to seek healthcare were the perception of not getting the required service or medicine, mistreatment from health workers, and a general mistrust of health clinics. These changes led to more households incurring extra costs as they sought treatment in private clinics and bought medicine from pharmacies or other sources.

NGO clinics remained the most reported source of treatment by refugees even though usage levels slightly fell during the pandemic.

In 2018, the most common source of medical treatment in every camp surveyed was NGO clinics (82%), followed by pharmacies or drug shops in the market (31%). Government-run and private medical clinics were the third most common source of medical treatment (5%). Traditional healers were the least used treatment source in most camps (4%) (J-MSNA Rohingya 2018). In 2019, NGO clinics (79%) were still the most common source of treatment, but private clinics became the second-largest source of medical treatment (29%), followed by pharmacies or drug shops (22%) (J-MSNA Rohingya 2019). This rise in the use of paid medical services resulted from people's dissatisfaction with NGO clinics. Driving factors given by the Rohingya (including long waiting times, the perception of not getting the required service or medicine, and being mistreated by health workers) led households that could afford it to prefer paid healthcare over free-of-charge services in NGO and government clinics (ACAPS 20/12/2019).

In 2020, NGO clinics were still the most common source of treatment, but their use dropped by 18%. A possible reason is people's fear of contracting COVID-19, since the use of all other health facilities also fell (J-MSNA Rohingya 2020). By 2021, the percentage of ill individuals seeking treatment at NGO clinics had again risen to 72%, followed by private clinics (25%) and pharmacies or drug stores (24%) (J-MSNA Rohingya 2021).

Figure 5. Percentage of Rohingya respondents using different health facilities based on MSNA data



Sources: J-MSNA Rohingya (2018, 2019, 2020, and 2021)

The most often perceived barrier for the Rohingya to accessing health services in 2021 was overcrowding. In 2018, 49% of refugee households reported experiencing challenges in accessing health services, including the unavailability of drugs and supplies (22%) and the distance to a clinic (18%). Only 15% of households reported overcrowding as a challenge (J-MSNA Rohingya 2018). Although health facilities continued to function in both the camps and host communities during the pandemic, the proportion of people who reported needing treatment significantly decreased in both communities in 2020. A likely reason is mistrust between healthcare workers and people seeking care, confidence in alternative healthcare sources, and the misunderstanding of COVID-19 protocols and quarantine and isolation rules that inhibited people from seeking medical advice when they were unwell (J-MSNA Rohingya 2020; ACAPS/IOM 28/04/2021).

In 2021, 44% of Rohingya refugees reported facing barriers to accessing treatment despite the lifting of COVID-19 restrictions. For refugees, these barriers included long waiting times and overcrowding (as reported by 24% of households), higher than in 2018, when comparable figures were available. Only six of 33 camps did not have sufficient health posts per WHO standards (Health Cluster 07/05/2022). Communication with operational responders revealed that most people tended to visit the health post at around the same time, often resulting in overcrowding. Consequently, some people would have felt unsatisfied with the service they received, as health facility staff were busy and were unable to give them the time and attention they thought they should have received. Other barriers mentioned were the unavailability of the specific medicine, treatment, or service needed (21%); the perception of not receiving the correct medication (11%); short opening hours; mistreatment in health centres; and not receiving medicine from the health posts, requiring them to purchase it outside. Despite the existence of free health services for refugees, 39% of Rohingya households reported incurring health-related expenditures, such as purchasing medicine in pharmacies or paying for treatment. Such an expenditure would often lead to negative coping strategies (J-MSNA Rohingya 2021).

Host community members expressed dissatisfaction with health services received in government hospitals. Some instead sought services from NGO-run health facilities in the Rohingya refugee camps (REVA 2019). Others continued to go into debt to pay for treatment in private facilities (J-MSNA Host 2019; ISCG 27/03/2022 a). In 2019, 21% of host community households reported that safety concerns were a barrier to accessing facilities in general (health, market, and education) (J-MSNA Host 2019). In 2021, the most cited barriers were similar to those faced by the Rohingya, with the addition of the distance to health facilities or a lack of transport. 19% of households reported being more than 30 minutes of travel distance away from the nearest functional health facility.

Figure 6. Percentage of households seeking treatment based on J-MSNA data.



Note: Data was not available for 2018

Sources: J-MSNA Rohingya (2019, 2020, and 2021); J-MSNA Host (2020 and 09/2021)

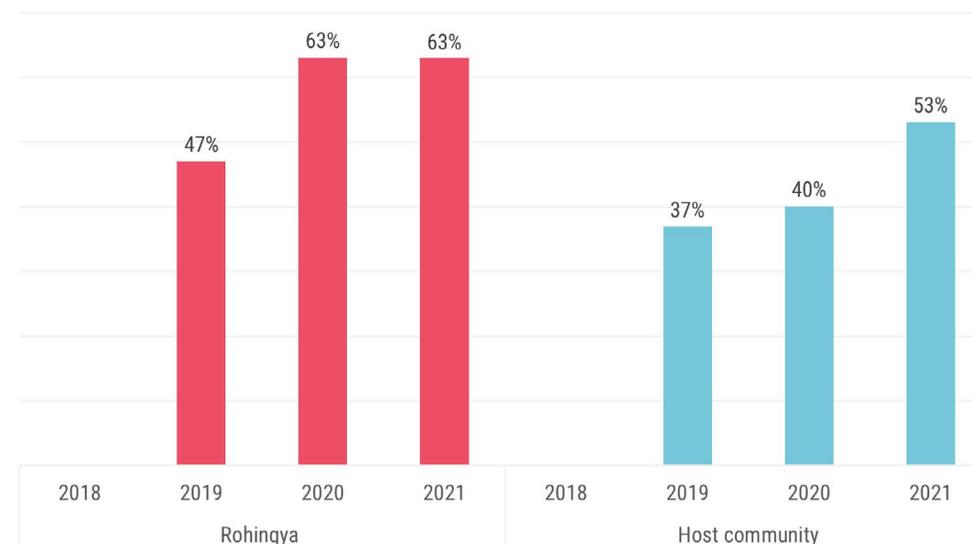
Shelter and NFIs

The need for shelter materials in the camps has not changed over time, as government restrictions force people to continue constructing shelter from non-durable materials (bamboo and tarpaulins). As such, shelters and other structures within the camps are not resilient to monsoon rains, flash floods, and landslides. Materials require regular replacement on a recurring basis because of weather- or fire-related damages. Shelter needs are expected to remain high for refugees. In the host community, where almost all households own or co-own their houses, repair needs are also a consistent issue.

For Bangladeshi households in the area, challenges in repairing buildings involve the affordability of materials and labour. A significant shift in NFI assistance to the refugees occurred in 2018 when the provision of LPG was introduced; up until then, people predominantly used firewood in the camps. The introduction of LPG had a positive impact in reducing environmental degradation and alleviating protection concerns for those collecting firewood. In 2020–2021, COVID-19 restrictions reduced the regularity of LPG refills.

In the host community, firewood remained the main cooking fuel as LPG assistance was not provided on a large scale. The lack of adequate lighting is a persistent concern among Rohingya households and remains one of the primary reasons people feel unsafe in camps at night. This need for adequate lighting persisted from 2017–2021 despite some distribution of solar lights.

Figure 7. Households that reported shelter materials as a priority need.



Note: data on shelter needs was not available in 2018. The absence of data does not indicate that shelter was not a priority.

Sources: J-MSNA Host (2018); ISCG (12/11/2020 a and 27/03/2021 a); J-MSNA Rohingya (2019, 2020, and 2021)

Shelter is a concern in both the Bangladeshi and Rohingya communities. High shelter needs persist in the camps because of regular and significant shelter damage. In 2017, 90% of Rohingya refugees lived in makeshift camps in shelters made with poor-quality materials. The combination of deforestation and fragile shelter materials exposed shelters to serious damage from severe weather (REVA 2017). Although almost all refugee households reported receiving shelter materials in 2018 (96%), concerns about the quality of materials were widespread (Shelter Cluster 07/10/2018). Since 2019, increasing numbers of households have reported shelter materials as a priority need, given the annual recurrence of monsoon damage, made worse when distributions ceased during the COVID-19 pandemic. In 2018, 19% of refugee households reported damaged shelters. In 2019, 81% of refugee households said they faced issues with their shelters, such as a leaking roof, rotten or damaged bamboo, and leaking walls (J-MSNA Rohingya 2019). Twice as many households in the camps reported shelter damages in 2020 compared to 2019, likely because of the combined effects of monsoons and limited access to camps during the COVID-19 pandemic (J-MSNA Rohingya 2020).

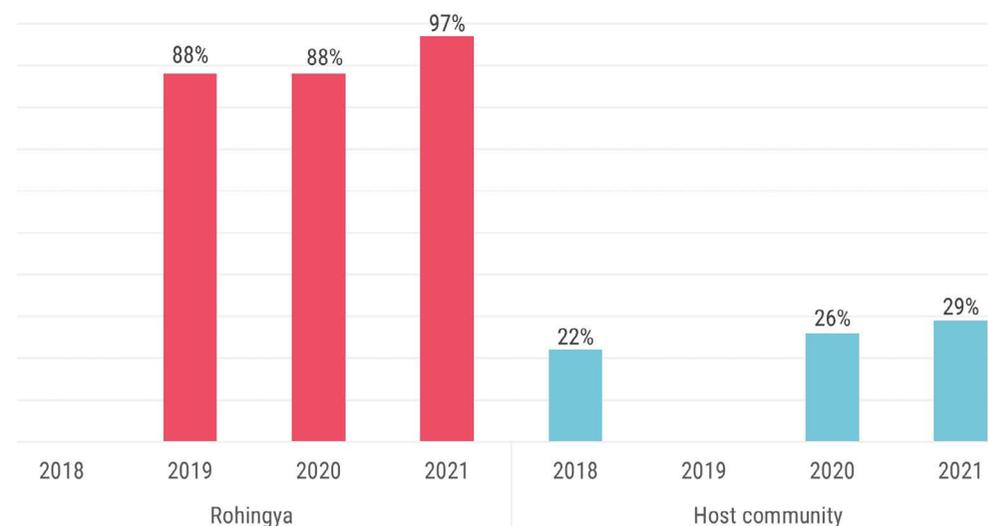
In the host community, almost all households own or co-own their houses. Often, these houses are jhuprie (a form of shelter made of earth, bamboo, wood, and corrugated iron sheets or thatch as roofs) or kutcha (a form of shelter made of branches, bags, tarpaulin, jute, and other

cheap materials), both vulnerable to weather impacts. In 2019, 37% of households did not make any improvements to their shelter in the six months before data collection, although they had reported the need to do so (J-MSNA Host 2019). In 2020, this number decreased to 24% (J-MSNA Host 2020). This decrease can be linked to the shelter assistance provided to the host community in 2020 before the COVID-19 pandemic. In 2021, more households (71%) reported shelter issues than in 2020 (59%), likely attributable to a large reduction in maintenance: 30% did not upgrade their houses even when they reported the need to do so. It is likely that COVID-19 restrictions, the reduced availability of materials, and a lack of money caused people to postpone upgrading and maintenance work. Only 1% of households who repaired their houses in 2021 received shelter assistance (ISCG 27/03/2022 a).

The primary source of cooking fuel among refugees has changed from firewood to LPG since it was introduced in 2018. At the beginning of the influx, four of five refugee households used firewood as cooking fuel (EC et al. 26/11/2017). In 2018, cooking fuel and stoves were reported to be the most needed NFIs in the camps (J-MSNA Rohingya 2018). 10% of refugees reported incurring debt to buy LPG and other basic items (REVA 2018). To meet this gap, responders introduced and scaled up the provision of LPG cylinders and stoves in August 2018 (Global Shelter Cluster 2018). By 2019, 88% of refugee households were using LPG as their primary source of cooking fuel, a number that remained consistent in 2020 (see figure 8) – although 98% of all households reported receiving LPG from humanitarians (J-MSNA Rohingya 2019 and 2020). LPG distribution also had a positive impact on protection because fewer households had to resort to collecting firewood, known to be a dangerous activity (REACH/UNHCR 31/07/2019). In 2020, Rohingya refugees reported challenges with LPG supplies, saying the amount delivered did not meet all their needs. They also struggled with the transportation of cylinders because of their weight and the distance they had to carry them. Some households had to pay for transportation as they did not qualify for free porter services (ACAPS/IOM 28/04/2021). In 2021, 97% of households reported receiving LPG refills, but half of the refills did not last the full time before refills were available (J-MSNA Rohingya 2021).

Approximately half of host community households reported using self-collected firewood as cooking fuel in 2019 (J-MSNA Host 2019). By 2020, the number was still over 40%, and only 26% were exclusively using LPG (J-MSNA Rohingya 2020). In 2021, 29% of host community households exclusively used LPG for cooking, and 32% of households bought LPG refills (J-MSNA Host 2021).

Figure 8. Percentage of households using LPG.



Note: data on shelter needs was not available in 2018 for the Rohingya refugees and in 2019 for the host population. The absence of data does not indicate that shelter was not a priority.

Sources: J-MSNA Rohingya (2019, 2020, and 2021); J-MSNA Host (2020 and 09/2021)

Generally, the types of NFIs that the refugees needed varied over time and by season, except for the need for lighting and lamps, which persisted from 2017–2021. In 2018, aside from fuel stoves for cooking, the primary need was solar lamps (53%) (J-MSNA Rohingya 2018). Although the need for stoves decreased in future assessments, the need for lamps was consistently reported from 2017–2021. A large proportion of households indicated inadequate lighting within shelters and public facilities, and the issue of inadequate lighting contributed to heightened safety concerns (ACAPS 30/04/2019). 82% of households reported not having enough light to access latrines safely (J-MSNA Rohingya 2018).

In January 2019, the need for solar lamps was 57%, and it was claimed as the most urgently needed NFI (UNHCR 28/03/2019). Later that year, more than one-third of households (40%) claimed to have no lamp in their households (ISCG 30/09/2019 a). In 2020, 58% of households reported issues regarding lack of light (J-MSNA Rohingya 2019 and 2020). This proportion increased to 66% in 2021, when one of the most reported needs among NFIs was solar lamps (ISCG 30/09/2019 a). A lack of knowledge about maintenance, the unavailability of technical guidance, and the stealing of lamps contributed to the consistent need for solar lamps (ACAPS/IOM 28/04/2021, Oxfam et al. 21/12/2018). This need may also indicate the inadequate provision of assistance, as there are reports of refugees continuing to sell items such as solar lamps as a coping strategy to address immediate needs, such as food (J-MSNA Rohingya 2019, 2020, and 2021; Oxfam et al. 21/12/2018).

WASH services

The quality of water in the camps has improved over time. The rate of *E. coli* (bacteria) contamination has decreased. Although the number of people with access to enough water for their daily needs has increased since 2017, however, the lack of water remained an issue for a third of households in 2021. COVID-19 restrictions decreased the maintenance of WASH facilities and led to overcrowding in the facilities that remained functional. Menstrual hygiene management (MHM) items have not been available in sufficient quantities from the start of the humanitarian response.

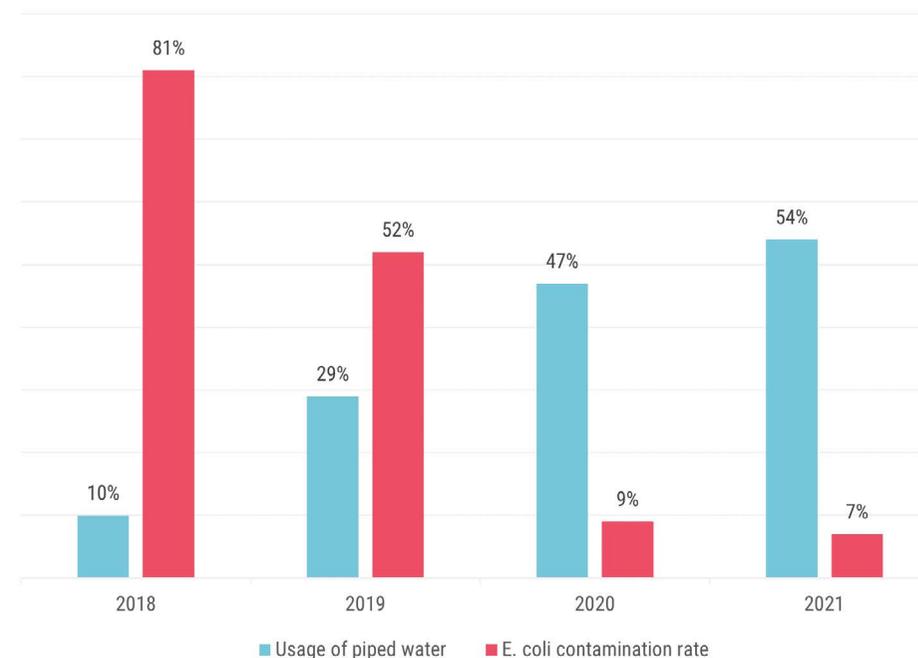
During the pandemic, availability and access to these items further decreased. In the host community, improved water sources were available to almost all households before the Rohingya influx. In 2020–2021, access to sufficient water became an issue for a third of host community households.

Assessments show that since the start of the pandemic, almost all households from both Rohingya and Bangladeshi communities have had access to soap, indicating that the maintenance of proper hygiene is possible.

Improved water sources have been increasingly available over time and reduced the risk of waterborne diseases. In 2018, tube wells were the main water source for refugees and the host community. The problem was that one-third of camp latrines were within 10m of a water source, putting water quality at risk (REVA 2017). Most water samples (81%) tested positive for *E. coli* that year (see figure 9) (WHO 07/05/2018). With the number of households with access to piped water increasing from 10% to 54% between 2018–2021, the risk of contamination and resultant waterborne diseases also significantly decreased (J-MSNA Rohingya 2021). While 46% of households remained without piped water, only 7% of water samples from water sources tested positive for *E. coli* in 2021, although 27% of samples from water stored by households tested positive. This outcome indicated the continued need for hygiene promotion focusing on the safe water chain (J-MSNA Rohingya 2021; GOB 10/09/2021).

Before the refugee influx, most host community households already had access to improved drinking water sources. They have seen no changes in water quality since.

Figure 9. Rohingya refugees' access to piped water and *E. coli* contamination rate.



Sources: J-MSNA Rohingya (2018, 2019, 2020, and 2021); WHO (07/05/2018); ISCG et al. (03/03/2020); Health Sector (31/12/2020); GOB (10/09/2021)

Despite improvements, a third of people (including both camp and host community populations) have problems accessing enough water. In the early stages of the refugee influx, half of the Rohingya refugees reported water access challenges, with water scarcity mostly concentrated in Teknaf (REVA 2017, REACH et al. 30/04/2018). For refugees, the main problems with accessing water included long distances to water points, insufficient facilities for water collection, and long waiting times (REACH et al. 30/04/2018). In 2020, COVID-19 restrictions prevented the repair of broken water points, reducing the number of functional pumps and water availability for drinking and hygiene purposes. Related impacts continued to be felt in 2021 (J-MSNA Rohingya 2020; ACAPS/IOM 28/04/2021).

Overcrowding at water points, a persistent problem since 2018, worsened in 2021 because of the limited number of functional water points, because some points were only open for short periods each day, or because women chose to fetch water at a specific time to avoid meeting men (ACAPS/IOM 28/04/2021). The impact of the challenges to accessing functional water points was that 31% of households reported not having enough water in 2021, up from 12% in 2020, although still below 56% in 2019 (J-MSNA Rohingya 2019 and 2020). In 2020, during the COVID-19 pandemic, 24% of host community households reported not having enough water to meet domestic needs, down from 35% in 2019 (J-MSNA Host 2019 and 2020). This situation worsened in 2021, when, similar to the Rohingya community, roughly one-third of host community households reported not having enough water (ISCG 27/03/2022 a). Some host community members sharing water points with the Rohingya or who lived near the camps said that sharing has been causing tensions between the two communities since 2018, as the water supply has not always been sufficient to meet the demand (IOM/ACAPS 28/04/2021; IRC 28/02/2019; CPJ/UNDP 06/2019).

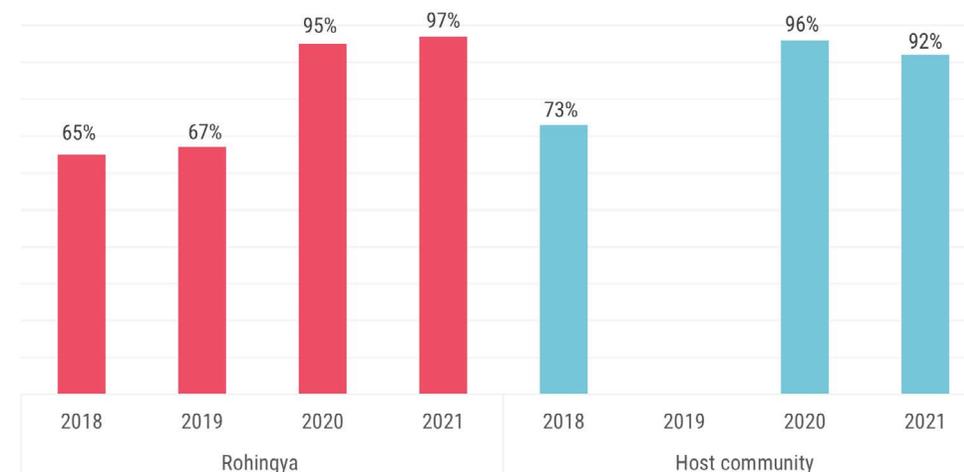
Overcrowding at communal WASH facilities continues to be an issue. In 2018, just over half the camp population (55%) used communal latrines. 53% reported difficulties accessing latrines because they were overcrowded, too far, or non-functional. 57% also reported that women and girls felt unsafe using latrines at night (REACH et al. 30/04/2018). 48% of households had access to communal bathing facilities, 38% had bathing areas set up within their households, and 10% had no designated bathing facility.

In 2019, poor maintenance was a commonly reported concern linked to overcrowding in WASH facilities. A WASH infrastructure assessment found that only 78% of latrines and 68% of bathing facilities were functional in the camps (UNICEF/REACH 09/2019). Inadequate facilities increased pressure on functional latrines. Part of the reason was it was unclear who was responsible for the maintenance of the remaining facilities (REACH/UNHCR 30/09/2019). By 2020, 68% of refugee households had a private space inside their shelters for bathing, a 30% increase from 2018 (IOM 17/09/2020). This increase has, however, compounded waste management issues, such as clogged drainage systems. Coupled with the switch to critical programming only during the COVID-19 pandemic, drainage issues likely contributed to

the increase in reports that public WASH facilities were not properly maintained (J-MSNA Rohingya 2020). Strict movement restrictions between camps, combined with weather-related damages to pedestrian infrastructure, also worsened access challenges, preventing some households from accessing alternative, functional WASH facilities, especially households with people with disabilities (ACAPS/IOM 25/08/2020). In 2021, 38% of households still reported problems related to latrines and 19% to public bathing facilities (J-MSNA Rohingya 2021). Most host community households (89%) had in-house latrines before the refugee influx (J-MSNA Host 2018). Nevertheless, many still used communal facilities. In 2019, 30% of households reported problems accessing communal latrines because they were unsafe and dirty and accessing community facilities because of long waiting times (J-MSNA Host 2018; REVA 2019). In 2021, the most commonly reported problems were unclean and dysfunctional communal latrines (J-MSNA Host 2021).

Soap availability has increased over time for both refugees and the host community, particularly since the pandemic. In 2018–2019, one-third of households reported not having soap at the time of data collection (REACH et al. 30/04/2018; J-MSNA Host 2018; ISCG 30/09/2019 a). By 2020, almost all households from both Rohingya and host communities reported having soap. This trend continued in 2021, although having insufficient soap was reported in 11 of 20 focus group discussions with the Rohingya for the 2021 J-MSNA (J-MSNA Rohingya 2020 and 2021; ISCG 12/11/2020 a; J-MSNA Host 2021). Soap availability indicates that people could observe personal hygiene practices in Rohingya and host community households, which might help improve health concerns in the long run.

Figure 10. Soap availability at the time of data collection based on J-MSNA data.



Note: data on soap availability in host communities was not available for 2019. This lack of data does not imply that there was no soap in the host community that year.

Sources: REACH et al. (30/04/2018); J-MSNA Host (2018, 09/2019, 2020, 08/2020, and 09/2021); J-MSNA Rohingya (2020 and 2021)

Women and girls continue to have insufficient access to MHM materials. In 2019, MHM services were being provided but were not fully available to all refugees. A primary reason was men tended to collect assistance, meaning women missed out on MHM awareness sessions held at the collection or distribution points (REACH/UNHCR 31/07/2019). Inconsistent distribution also forced the reuse of menstrual cloths (REACH/UNHCR 30/09/2019). COVID-19 restrictions aggravated these issues, with delays in the provision of MHM materials and reduced access to communal WASH facilities. The more constant presence of men in the shelters because of COVID-19 mitigation measures also hampered the washing and drying of menstrual cloths (ISCG 14/10/2020). In 2021, Rohingya women continued to report having insufficient and poor-quality menstrual hygiene kits (J-MSNA Rohingya 2021).

In the host community, MHM remained unaffordable and inaccessible for many women. In 2018, nearly one-third (28%) of female respondents said they could not afford MHM materials because households prioritised other household needs (J-MSNA Host 2018). In 2020, this number increased; 40% of Bangladeshi women in the host community reported not having enough access to menstrual items (ISCG et al. 14/10/2020). Some women living near the camps said they borrowed menstrual hygiene items from Rohingya women to cope (ACAPS/IOM 27/04/2020). In the 2021 J-MSNA, the issue of MHMs was not specifically reported on by the host community.

Protection and security

It is difficult to identify trends for protection concerns, including GBV and child protection concerns, which involve exploitation (including trafficking, child labour, and sex work), child marriage, and substance abuse because of the absence of comparable data often related to the sensitive nature of reporting these events (Save the Children et al. 01/2019).

Findings from J-MSNA focus group discussions indicate that child protection issues and GBV incidents increased during the COVID-19 pandemic. The lack of data also highlights the limitations of remote data collection on protection issues, where respondents are less likely to feel safe to discuss sensitive issues and have concerns over privacy and confidentiality, likely resulting in significant under-reporting.

Many protection issues in the refugee community that continue to be reported are closely connected to concerns expressed over shelter and WASH arrangements offering inadequate privacy and a lack of lighting in shelters at night, as discussed in respective sections of this report. Overall, Rohingya refugees are not satisfied with the protection services provided and often continue to instead seek advice from Majhis and the CiC, which can put them at risk of exploitation. The host community reports feeling increasingly insecure since the beginning of the influx, along with increased reports of kidnapping, road accidents, and drug smuggling and selling.

Available data from assessments based on focus group discussions and according to protection responders indicates that COVID-19 mitigation measures aggravated GBV and child protection incidences in the camps. GBV is believed to have been under-reported in Rohingya and host communities since the beginning of the influx. The underlying factors are a combination of cultural norms, women's limited understanding of their rights, and the social stigma attached to reporting GBV (Oxfam et al. 01/08/2018; ACAPS 28/04/2021).

In 2019, data from 19 centres operated by the International Rescue Committee (IRC) across 19 Rohingya camps that screened for GBV incidents indicated that at least one in four women or girls screened between July–December 2019 was a survivor of GBV (IRC 10/06/2020). Just over a year later, IRC protection monitoring data showed both Rohingya refugees and the host community reported an increase in GBV cases since the onset of the pandemic (UN Women et al. 09/2020). Women reported that their husbands, frustrated by the loss of livelihood opportunities, became increasingly violent towards women in the household (AI 15/09/2020). Despite this increase in GBV, IRC protection monitoring data in 2020 revealed a 50% decrease in the number of women and girls accessing women's protection and empowerment services since the implementation of COVID-19 containment measures (IRC 10/06/2020 and 22/01/2021).

Referral pathways and services for GBV prevention and response have improved since the influx began in 2017, but access was limited during lockdowns. Overall, mobility restrictions and cultural factors keep access to such services challenging (ISCG 30/09/2019 b). COVID-19 containment measures added access constraints with the suspension of GBV prevention activities, reduced mobility, and people's fear of getting infected or being forcibly isolated if identified as a COVID-19 patient (ACAPS 08/06/2020; IRC 22/01/2021). (ISCG 30/09/2019). In June 2021, Protection Emergency Response Units were activated and provided critical protection support in 32 camps, including awareness-raising, basic emergency case management, and child protection and GBV expertise (ISCG 06/09/2021).

Children's concerns about their safety in the camps have been affecting their access to basic services and encouraged unhealthy coping techniques since the beginning of the influx.

This perception of insecurity originates from a combination of factors, such as inadequately lit and overcrowded camps, unsafe shelters, and exposure to incidences of violence (ACAPS 21/11/2019). In 2018, the most reported concerns among children and adolescents were the fear of being kidnapped, harassment, break-ins to their shelters (as they cannot lock their doors), and the risk of violence and sexual assault (PI et al. 24/02/2018).

Child-friendly spaces had been provided as a child protection service early in the response, but they were not enough, and existing ones were not well equipped with age-appropriate materials (WVI 17/11/2017; Save the Children et al. 01/2019). As a result, adolescents tended to go outside camps, exposing them to the risk of beating, abuse, and exploitation and worsening their risk of trafficking, child labour, and child marriage (Save the Children et al. 01/2019; ACAPS 21/11/2019).

Children became involved in drug trafficking because of unemployment and poverty, although adolescents reported that the reason drug traffickers used children was also that authorities were less likely to search them (Save the Children et al. 01/2019). In 2019, 5% of households reported having at least one child involved in an income-generating activity and at least one member under the age of 18 already married or pledged to be married (J-MSNA Rohingya 2019).

COVID-19 and the accompanying containment and risk mitigation measures reduced children's exposure to risks outside the camps but increased their exposure to the risks inherent in daily life in the camps. The ensuing economic hardship for households contributed to the increase in child marriage for girls, child labour, and child trafficking (Protection Cluster 27/01/2022). The prolonged closure of learning centres (LCs) also removed access to the protective environment they provided, increasing children's exposure to protection issues. 16% of households reported an increase in child labour and abductions, and 9% reported an increase in child marriage (J-MSNA Rohingya 2020).

Children in the host community, particularly adolescent girls who faced tighter movement restrictions than boys and younger girls, had been feeling insecure since the beginning of the influx (ACAPS 21/11/2019). The host community reported an increase in kidnapping, road accidents, and drug smuggling and selling, putting children, specifically adolescent boys, at more risk. Young children from poor households also started getting involved in child labour by selling products in camps to supplement their parents' income (Population Council/UNFPA 10/2018). The host community population showed very limited knowledge about protection services (IOM 06/2019). Protection concerns increased when the pandemic closed schools. In 2020, 49% of host community households reported an increase in child labour and 20% an increase in child marriage. There was a 7% increase in numbers reporting children experiencing psychological distress (J-MSNA Host 2020). By 2021, host community children were facing issues similar to refugee children's in terms of protection risks. Driving factors included COVID-19 and related mitigation measures, such as school closures, and limited household income (Protection Cluster 27/01/2022).

Rohingya refugees continue to seek assistance from Majhis and the CiC for problems, including those of a protection nature, instead of accessing services from humanitarian organisations. Although humanitarian organisations have put strategies in place to respond to protection issues, the Rohingya still prefer to seek support for sensitive issues like GBV from Majhis rather than from humanitarian or government responders and facilities (J-MSNA Rohingya 2019, 2020, and 2021). The percentage of people consulting Majhis has been consistently high since the influx. In 2019, the preferred point of contact in a hypothetical scenario where respondents needed to refer a sexually assaulted friend for care and support was the Majhi for 83% of those surveyed. By the end of 2021, people named both Majhis and the CiC as figures they would go to in such a situation: 81% would consult the Majhi, and 79% would consult the CiC.

This unchanged trend favouring the Majhis is concerning because there have also been allegations of favouritism, abuse of power, and inappropriate conflict resolution approaches in the Majhi system (J-MSNA Rohingya 2020 and 2021; ACAPS/IOM 28/04/2021). It is unclear but possible that people may feel the need to acknowledge the importance of the Majhi because of the power and control Majhis have established. Another factor is that people may fear that their answers to assessment questions are not confidential. COVID-19-related restrictions forcing the closure of protection services between April–September 2021 and a limited understanding of protection services appeared to have negated efforts to inform people about and encourage them to use official protection services.

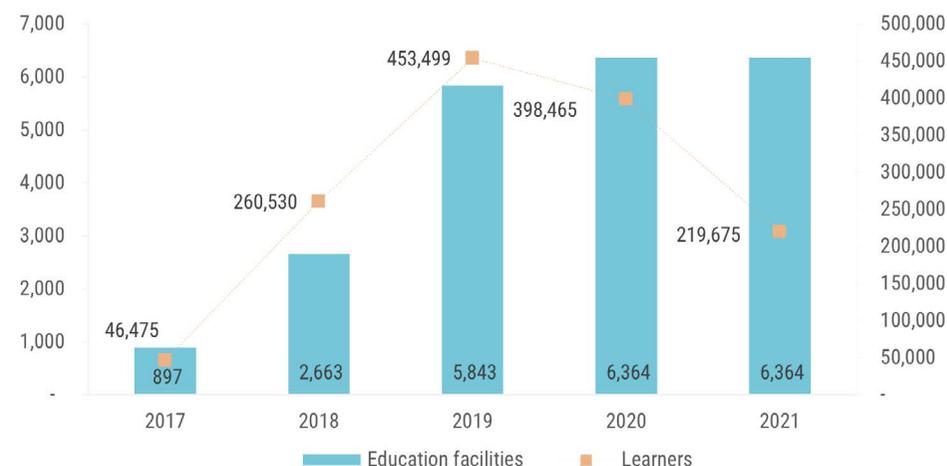
Education

Access to education for Rohingya children in the camps remains challenging. While the number of education facilities increased sevenfold between 2017–2020, the number of school-age children also increased, and many older children currently receive either no education or education with private tutors that must be paid for.

The availability of suitable education facilities and resources decreased, with the Rohingya influx reducing access to and the quality of education for host community children. COVID-19 mitigation measures resulted in the closure of LCs and schools, in camps and Bangladeshi communities, for more than 18 months, halving the number of children able to access learning in 2021.

Access to quality education has improved but remains insufficient, especially for older students.

Figure 11. Number of education facilities and learners in camps in Ukhia and Teknaf (2017–2020).



Source: Education Sector 5W monthly reporting

YEAR	TARGETED	ENROLLED	% ENROLLED
2017	230,000	46,475	20%
2018	540,000	260,530	48%
2019	462,460	452,499	98%
2020	421,760	398,465	94%
2021	451,548	220,630	49%
2022 (until June)	469,882	356,363	76%

Source: Education sector KII

Initially, the camps had insufficient LCs to accommodate all new refugee children (UNICEF 29/09/2017; REVA 2017). By 2019, the educational infrastructure in the camps had improved, and the attendance of children ages 3–14 had substantially increased (REACH 03/2019). A new approach to education, the Learning Competencies Framework and Approach, was introduced and progressively rolled out in 2019 (UNICEF 05/12/2019). This programme improved the quality of education for children ages 3–14. Barriers for older Rohingya students persisted, as they faced a less structured curriculum and significantly fewer opportunities to have an education facility in their camp. Only 3% of the LCs offered services for children above 14

years of age. The main barriers to education reported by boys included irrelevant or age-inappropriate learning (reported by 52% of boys). The barriers reported by girls were those related to cultural norms and families' tendency to withdraw girls from public life after puberty. Factors affecting the latter involved concerns around girls bringing shame to the family or ruining their chances of marriage, perceptions that there is limited utility to educating girls in terms of the low likelihood of them getting jobs, and concerns about being harassed by men and boys. These so-called cultural barriers were reported by 65% of girls. 24% reported child marriage as a direct barrier to attending classes (REACH 03/2019). Involvement in livelihoods and domestic work are additional impediments to educational quality for older children (REVA 2017; ISCG 12/11/2020 b; REACH et al. 29/03/2021).

In January 2020, the Government of Bangladesh approved the use of the Myanmar curriculum in the camps (AI 15/09/2020). In mid-March 2020, COVID-19 and the accompanying containment and risk mitigation measures shut down all LCs and schools serving both Rohingya and Bangladeshi children (REACH et al. 29/03/2021). Schools and LCs remained closed until 22 September 2021 (RRRC 20/09/2021). Education assessments found that more than three-quarters of Rohingya children continued their studies from home, with small-scale support from Rohingya volunteers and teachers and the provision of stationery and learning materials (UNICEF 02/06/2020).

Remote learning has been challenging for children in Rohingya camps given limited resources. Impediments include limited internet and mobile network connection, a lack of learning materials, the unavailability of teachers, a lack of guidance from teachers, and the unavailability of educated household members to support children with their studies (REACH et al. 29/03/2021; J-MSNA Rohingya 2020). In 2020, 62% of households reported facing challenges in supporting their children's remote study (J-MSNA Rohingya 2020). Households also reported older children getting involved in child labour and child marriage, putting many (both boys and girls) at risk of not returning to school at all (REVA 2020; J-MSNA Rohingya 2021). In 2021, Rohingya refugees expressed discontent with the LCs, specifically about the poor quality of education, disinterested Bangladeshi teachers, and a lack of progressively increasing difficulty levels upon finishing each year of study (ACAPS/IOM 28/04/2021).

After COVID-19-related delays, the UN and its partners launched the Myanmar Curriculum Pilot in November 2021, with phase one targeting older children (grades six to nine, generally in the age bracket of approximately 14 years onwards). A total of 12,038 (2,210 girls and 9,828 boys) were enrolled as at 22 May 2022 (UNICEF 01/05/2022; Education Sector KII). It is difficult to accurately understand the proportion of eligible children covered because of differences in the age groups used in the demographic breakdown of refugee population figures. To give an approximate idea, UNHCR figures indicate that there were 64,415 girls and 69,504 boys in the 12–17 age group in the camps as at 31 July 2022 (UNHCR 13/08/2022). While the introduction of the Learning Competencies Framework and Approach and the Myanmar curriculum are likely

to improve education quality for all children regardless of age and prepare them for future employment, opportunities for them to work and improve their quality of life remain severely restricted (J-MSNA Rohingya 2020).

The literacy rate among the refugees who arrived in Bangladesh in 2017 was lower (27%) than that of refugees who arrived before the influx. The Rohingya who arrived in previous influxes had a similar literacy rate as members of the adjacent Bangladeshi host community (approximately 39%) (REVA 2017; Oxfam et al. 01/08/2018). They likely benefitted from having access to the education system in Bangladesh.

The access to education of children in the host community is deteriorating. During and immediately after the 2017 influx, the initial use of many schools as shelters for newly arrived refugees and temporary camps for law enforcement institutions reduced access to education for Bangladeshi children (REVA 2017; UNDP 27/07/2019). Even after shelters were built for refugees, permitting Bangladeshi children to return to their schools, education deteriorated in schools near the camps because some school staff chose to work in the Rohingya refugee response for higher salaries (J-MSNA Host 2018). Barriers to education also included the cost of education, being engaged in household chores or economic activities, increased feelings of insecurity attributed to criminality, long distances to schools, and road traffic congestion. The influx worsened many of these barriers (UNDP 27/07/2019; J-MSNA Host 2018). These challenges persisted until 2019. The pandemic added additional challenges, such as a lack of resources and a lack of support for home-based learning (J-MSNA Host 2019; ISCG 27/03/2022 a). Like their Rohingya peers, Bangladeshi children struggled to access education during the pandemic, with most children unable to continue their schooling at home once schools were closed (REVA 2020). Some children from wealthy households had access to remote learning via smartphones (J-MSNA Host 2020).

Nutrition

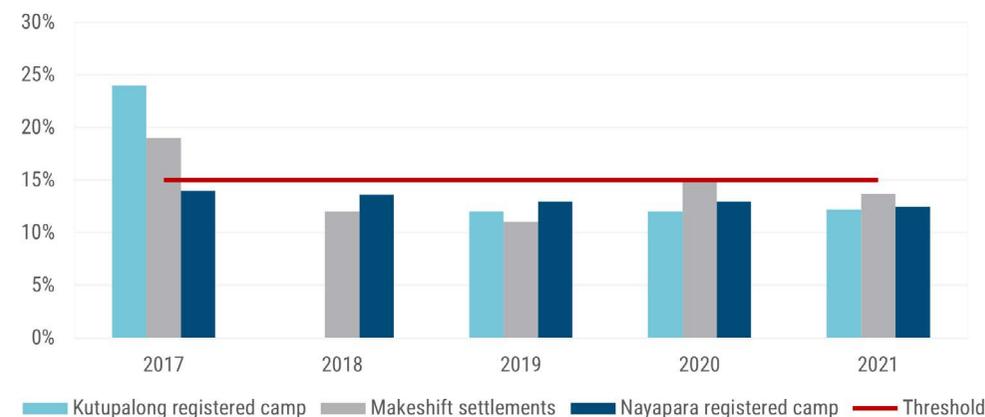
Early in the response, in 2018, the prevalence of acute malnutrition improved among refugee children with the help of humanitarian assistance. Since 2018, the GAM rate has remained relatively stable and has fallen within the WHO acceptable threshold rate in the camps. COVID-19 mitigation measures in 2020 led to the GAM rate increasing by almost 4% in the makeshift camps, to the WHO emergency threshold of 15%.

In the old camps of Kutupalong and Nayapara, the GAM rate remained stable in 2020 and improved in 2021. In the host community, GAM prevalence rates slightly decreased from 11.4% in 2018 to around 10% in 2021.

GAM prevalence fluctuated but remained above 10% from 2017–2021. Nutrition findings from the end of 2017 indicated a GAM rate of 19.3% among newly arrived Rohingya children ages 6–59 months, almost 5% above the WHO emergency threshold of 15%. GAM prevalence was even higher among those in the Kutupalong registered camp (also sometimes referred to as the old camps) at 24.3%, even though they had been receiving humanitarian support for two decades (ACF 27/11/2017). The higher rate in this group likely resulted from a combination of aggravating factors, such as substandard WASH facilities, poor living conditions in shelters, and the impact of natural disasters (UNHCR 09/10/2018). In the Nayapara registered camp in Teknaf, the GAM rate remained high at 14.3% (ACF 27/11/2017). To address the issue, humanitarians scaled up nutrition assistance programmes and identified and admitted children with severe acute malnutrition to therapeutic feeding programmes (REVA 2017).

By the end of 2018, the GAM rate had decreased to 13.6% in the makeshift camps and 12% in the Nayapara registered camp. Data for the Kutupalong registered camp was unavailable (ACF 02/12/2018). Among host community children, GAM prevalence was at 12.5% in 2018, very similar to the prevalence among refugee children.

Figure 12. Prevalence of GAM in Rohingya Camps.



Sources: ACF (27/11/2017, 02/12/2018, 23/10/2019, and 19/12/2020); ACF (accessed 24/08/2022)

The programme coverage for the community-based management of acute malnutrition significantly increased from 2018–2019 for both the Outpatient Therapeutic Programme (OTP) and Targeted Supplementary Feeding Programme (TSFP) (ACF accessed DD/MM/2022). As a result, in the last quarter of 2019, the GAM rate had decreased to 10.9% in the makeshift camps, 12.1% in the Kutupalong registered camp, and 13.3% in the Nayapara registered camp (ACF 23/10/2019).

Dissatisfaction with nutrition services in both the camps and the host community rose during the COVID-19 pandemic. The percentage of people expressing dissatisfaction with nutritional services rose from 16% to 25% in the camps in 2020. The specific dissatisfaction stated in the J-MSNA was the irregular nature of nutrition support, possibly attributable to the scaling down of some services (J-MSNA Rohingya 2020). The host community also expressed an increase in dissatisfaction with nutrition services during the pandemic (from 28% to 32%).

As COVID-19 restrictions increased cases of acute malnutrition, responders took additional actions. They scaled up the coverage of the OTP and TSFP in 2020. By 2021, 97% of camp households with children ages 6–59 months reported having had some form of contact with nutrition service providers, including screening (i.e. identifying those who should benefit from a nutrition assessment or intervention) and supplementary feeding (ISCG 27/03/2022 b). As a result, the GAM rate in the makeshift camps decreased slightly to 13.7% (ACF 19/12/2020). Despite the additional measures introduced and the falling GAM rate, dissatisfaction with nutritional services persisted until 2021 (J-MSNA Rohingya 2020 and 2021). In the host community, nutrition services during the pandemic saw the GAM rate decrease from 11.4% in 2018 to below 10% by 2021 (ACF 03/07/2018 and 23/06/2021).

Communication, information provision, and accountability to affected people

Within a year of the 2017 refugee influx, most of the Rohingya and the host community reported having sufficient information to make informed decisions, but ensuring all-encompassing accountability remained challenging.

Efforts to improve Accountability to Affected Population led to a steady increase in the proportion of both Rohingya and host community populations reporting to have provided feedback using a complaints and feedback mechanism (CFM). Alongside this increased reporting was a gradual increase in people expressing confidence that humanitarians were considering their feedback and opinions.

The progress took a step backwards when COVID-19 restrictions severely reduced the capacity of humanitarian responders to carry out in-person messaging on COVID-19 and, more broadly, other Communicating with Communities issues. The restrictions resulted in a steep drop in the number of families reporting confidence that the humanitarian community considered their opinions.

The information provision system to help both Rohingya and host communities make informed decisions improved before COVID-19 but was disrupted by the pandemic. By mid-2019, 51% of Rohingya households said they knew how to find an information hub, and 55% said they knew how to provide feedback (ISCG 06/2019). These figures were an improvement on the findings of assessments conducted soon after the influx. In November 2017, two months after the influx, only 23% of Rohingya refugees and 16% of host community members felt they had enough information to make informed decisions for themselves or their families. In these initial stages of the response, there were differences between the types of information the two communities were seeking. Refugees looked for basic life-saving information about getting food and water, while the host community was more concerned with security issues and general updates on news in the country, how to stay safe, and what to do in case of attack or harassment (Internews 28/11/2017).

By September 2018, specific assessments were showing improvements in the situation. 84% of refugees and 89% of Bangladeshis said they had enough information to make informed decisions pursuing their daily activities. The development likely resulted from the response putting in place information-sharing mechanisms involving community leaders, agencies, and camp-level coordination structures. For example, humanitarians had installed 68 information hubs by 2018 (BBC Media Action et al. 05/09/2018).

In 2020, with the emergence of COVID-19 and the increased spreading of rumours, access to accurate information on not only the pandemic but also other hazards, such as cyclones, became challenging. 37% of Rohingya households reported not receiving enough information on the provision of humanitarian assistance after the introduction of COVID-19 limitations (ISCG 12/11/2020 b). 45% of host community households also reported not receiving cyclone early warnings and other similar information (J-MSNA Host 2020). In 2021, 74% of Rohingya households reported not receiving enough information on at least one type of humanitarian assistance, while 99% of host community households who received assistance did not receive enough information about at least one type of assistance (J-MSNA Rohingya 2021). These findings are likely still a result of the reduced service provision that started with the onset of COVID-19.

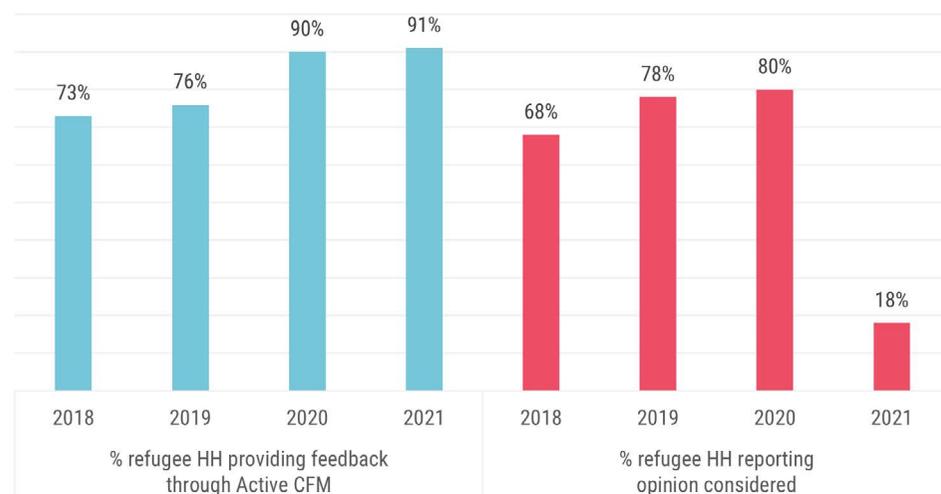
The scaling down of assistance hampered public health messaging during COVID-19. In March 2020, humanitarians disseminated public health messaging focusing on the prevention of the spread of COVID-19. Other related mitigation measures and the subsequent access constraints during the pandemic. COVID-19 mitigation measures and the subsequent access constraints affected the ability of humanitarians to continue with face-to-face messaging, forcing them to rely on only messaging that could be delivered remotely. As the pandemic situation quickly evolved and humanitarian presence scaled down by almost 80%, responders sometimes ended up communicating changes in programming retroactively, leaving the Rohingya feeling abandoned and confused (IOM/ACAPS 02/04/2020; BBC Media Action/TWB 20/05/2020).

Among both the Rohingya and host communities, people with disabilities and people with less access to public spaces, such as women, older people, and adolescent girls, faced greater barriers to accessing information and had less knowledge about COVID-19 (BBC Media Action/TWB 17/09/2020; ACAPS/IOM 07/04/2020).

Participation in the CFM increased, but people's perception that humanitarians considered their feedback decreased during the pandemic. Engagement in the CFM steadily increased from 2018–2021, with the number of households reporting problems in providing feedback or reporting complaints dropping by 25% to 9% J-MSNA Rohingya (2018, 2019, 2020, and 2021).

Similarly, from 2018–2020, there was a gradual increase to 80% in the overall number of people who felt that responders considered their opinions for aid provision (see figure 12) (GTS 13/12/2018). Despite this continuous improvement, the emergence of COVID-19 led to Rohingya refugees increasingly reporting not feeling adequately consulted or that humanitarians did not consider their opinions in decision-making and programming (ACAPS/IOM 28/04/2021).

Figure 13. Percentage of refugee households providing feedback through the CFM without any barriers and those considering their feedback to have been taken into account by aid providers.



Sources: J-MSNA Rohingya (2018, 2019, 2020, and 2021), GTS (accessed 24/08/2022).

In 2021, while only 9% of households reported facing challenges when providing feedback or complaints, the majority of both Rohingyas (82%) and host community members (66%) reported perceiving that humanitarians did not consider their feedback when decision-making J-MSNA Rohingya 2021; GTS accessed 24/08/2022). This issue is potentially explained by the scaling down of humanitarian operations in both communities to adhere to COVID-19 containment measures, which resulted in the adaptation of procedures for providing services without community consultation. Another potential factor may be the methodology of the study done by Ground Truth Solutions: in 2018–2020, the survey used only Bangladeshi enumerators, but in 2021, Rohingya volunteers also conducted the survey. Studies show that enumerator ethnicity influences participants' responses (GTS 27/05/2021).

ANNEX 1 - GLOSSARY OF KEY TERMS 1/4

Bhasan Char

A 40km² island in Hatiya upazila, Noakhali district, located in the Bay of Bengal approximately 60km away from the coast.

The island formed through sedimentation and emerged only in the past decade.

According to the Government of Bangladesh, they plan to relocate up to 100,000 Rohingya refugees to Bhasan Char. Relocation started in December 2020 (Reuters accessed 10/08/2022).

Camp In Charge (CiC)

The Refugee Relief and Repatriation Commissioner appoints the CiC, whom the authorities task to perform site management and administration duties in the Rohingya refugee sites (Cook and Ne 01/072018). Each camp has a CiC.

Camps (Registered Camps, Makeshift Camps, Old Camps Of Kutupalong and Nayapara)

Kutupalong refugee camp and Nayapara refugee camp, both in the upazila of Ukhia in Cox's Bazar, are often referred to as the 'old camps' or the 'registered camps' because they existed before the 2017 influx.

The Government of Bangladesh runs these two camps, home to 35,519 Rohingya refugees registered in 1991–1992.

The 2017 refugee influx resulted in the establishment of multiple camps around these camps (aside from camps closer to the Myanmar border in the upazila of Teknaf). This large conglomeration of camps is sometimes referred to as the Kutupalong megacamp, while all the camps established after the 2017 influx (i.e. those in Ukhia and Teknaf) are also referred to as the 'makeshift camps' or the 'new camps' (Devex 19/10/2017; UNHCR 28/01/2013; Mark Issacs accessed 10/08/2022).

Casual Labour

Casual work or labour is a form of temporary employment defined as the engagement of workers on a very short term or on an occasional and intermittent basis, often for a specific number of hours, days, or weeks, in return for a wage set by the terms of the daily or periodic work agreement (ILO accessed 10/08/2022).

Complaints and Feedback Mechanism

A complaints and feedback mechanism is a system that "receives, processes, and responds to concerns from the community on humanitarian services, assistance, or behaviour". Ways to give feedback can be in person, through suggestion boxes, via voice recorders, through hotlines or toll-free lines, or through community consultations (TWB accessed 10/08/2022).

Emergency Coping Strategies

Coping strategies are ways people employ to meet needs. Most work on coping strategies in the humanitarian sector has been related to food security, so most coping strategies are understood in terms of how people meet food needs.

Some coping strategies are more detrimental or harmful than others, usually because of their irreversible or difficult-to-reverse nature.

The Coping Strategies Index is an indicator of a household's food security. It assesses the extent to which households use harmful coping strategies when they do not have enough food or money to buy food. The result is reported by a numeric score.

Food Assistance

'Food assistance' is the terminology used to represent how people's food- and nutrition-related needs are understood. It marks a shift from the use of the term 'food aid'.

Food assistance is linked to ideas around giving people a voice and a choice in what food they receive and how they receive it. It is also linked to the transition from in-kind food assistance to cash-based transfers.

In Cox's Bazar, food assistance is primarily in the form of e-vouchers, which gives the Rohingya the freedom to shop for their preferred foods at a network of WFP retail outlets. The outlets offer common staples, such as rice, fortified cooking oil, eggs, and lentils. They also include fresh food corners with a selection of seasonal produce purchased directly from smallholder farmers in and around Cox's Bazar (WFP 10/03/2020; WFP accessed 11/08/2022).

ANNEX 1 - GLOSSARY OF KEY TERMS 2/4

Food Consumption Score (FCS)

The FCS is a score calculated using the frequency of consumption of different food groups by a household in the seven days before a survey (WFP 03/02/2015).

Food-Related Coping Strategies

Food-related coping strategies are ways that households address their needs through changes in food consumption patterns, including consuming less food, consuming lower-quality food, eating less preferred foods, and prioritising particular household members in terms of access to food (e.g. earning members, children) (Farzana et al. 14/04/2017).

Fresh Food Corners

Fresh food corners are stores or shops in the refugee camps that are part of the WFP e-voucher system. They offer a selection of seasonal produce, including chicken and fish, purchased directly from smallholder farmers in and around Cox's Bazar (WFP 31/12/2021, 02/09/2021, and 08/08/2021; UNB 28/10/2020).

Gender-Based Violence (GBV)

"Gender-based violence (GBV) refers to harmful acts directed at an individual or a group of individuals based on their gender. It is rooted in gender inequality, the abuse of power, and harmful norms. The term is primarily used to underscore the fact that structural, gender-based power differentials place women and girls at risk for multiple forms of violence. While women and girls suffer disproportionately from GBV, men and boys can also be targeted" (UN WOMEN 24/11/2020).

Gender-Responsive Policing

"Gender-responsive policing means that the needs of all parts of the community, women and girls, men and boys, including minority or marginalised groups, are considered to ensure no group is disadvantaged over another in its treatment by the police" (IAWP accessed 11/08/2022).

Global Acute Malnutrition (GAM)

GAM is the presence of both moderate acute malnutrition and severe acute malnutrition in a population. It is based on the weight and height of children under 59 months of age.

Weight-for-height (wasting) provides the clearest picture of **acute malnutrition** in a population at a specific time.

Moderate acute malnutrition is identified by moderate wasting.

Severe acute malnutrition is identified by severe wasting.

A GAM value of more than 10% for a population indicates an emergency. Commonly used thresholds for GAM are:

<5% - acceptable

5–9.9% - poor

10–14.9% - serious

>15% - critical (WHO 2000).

Host Communities

Host communities refer to the people living in the upazilas of Ukhia and Teknaf in Cox's Bazar district.

Improved Drinking Water Sources

Improved drinking water sources refer to water sources that by the nature of their construction adequately protect the source from outside contamination, in particular with faecal matter.

Improved drinking water sources include public taps or standpipes, tube wells or boreholes, protected dug wells, protected springs, and rainwater collection (SSWM accessed 11/08/2022).

In-Kind Support

In-kind support refers to humanitarian assistance provided in the form of physical goods or commodities. It is restricted by default as recipients are not able to choose what they are given (CALP 13/08/2021).

ANNEX 1 - GLOSSARY OF KEY TERMS 3/4

Indicators	For this report, an indicator is considered a measure of assistance supplied versus the needs expressed by the population (both Rohingya and host communities) at a certain moment in time. Indicators are informed through questions asked in assessments.	Learning Centre (LC)	A learning centre (or facility) refers to the physical structure where learners attend classes in the camps. The terminology differs in the host communities where the physical structure is referred to as a school (Education Sector).
Information Hub	Information hubs are also referred to as ‘information centres’ (UNICEF), ‘information points’ (UNHCR), or ‘mobile information and feedback centres’ (Red Cross/Red Crescent Movement). A mixture of national partners, INGOs, and entities such as Radio Naf 99.2 FM, Alliance for Corporate and Legal Aid Bangladesh, and the Red Cross/Red Crescent Movement run these hubs. They offer a face-to-face service providing advice and information, making referrals to service providers and recording complaints (CDAC Network 01/07/2018).	Learning Competencies Framework Agreement (LCFA)	The LCFA is a competency-based course of study where children progress based on competencies rather than age. The LCFA comprises levels one to four (Education Sector).
Jhuprie	A jhuprie is a type of construction for houses or other buildings made of earth, bamboo, wood, and corrugated iron sheets or thatch as roofs.	Majhi	In Myanmar, Rohingya people use the term ‘Majhi’ to refer to someone who leads a group and assists them in every possible way. Bangladeshi government officials have adopted the term to refer to community members appointed by the Bangladesh Government to be the leader of a block, which is a subsection of a refugee camp (TWB 12/10/2020).
Kutcha	A kutcha is a type of construction for houses and other buildings made of branches, bags, tarpaulin, jute, and other found or low-cost materials.	Megacamp	The Kutupalong network of camps in Ukha upazila is referred to as the megacamp, the Kutupalong expansion site, or the makeshift camps. As at February 2021, it included about 26 subcamps and housed over 700,000 of the approximately 880,000 Rohingya refugees in Cox’s Bazar (UN 23/03/2021).
Learners	The education sector uses the term ‘learners’ to refer to those enrolled or registered in learning facilities. The word ‘learners’ is used because under the Learning Competencies Framework Agreement (see below), learners are considered in terms of where they fit within the framework rather than their age group. The framework includes people between the ages of 3–24, meaning not everyone in the group are children (Education Sector).		

ANNEX 1 - GLOSSARY OF KEY TERMS 4/4

Menstrual Hygiene Management (Mhm)

MHM comes under the WASH sector. It includes all needs associated with MHM. Interventions include the distribution of menstrual hygiene materials and the dissemination of information regarding menstrual hygiene. There have also been efforts by a few WASH responders to make latrines and bathing facilities MHM-friendly by providing washing platforms to hygienically wash menstrual items and in-built chutes for the disposal of used menstrual cloths and pads (ISCG et al. 26/02/2020).

NEEDS**Basic Needs**

Basic needs refer to the basic goods and services (such as food, shelter, clothing, sanitation, and education) necessary for a minimum standard of living (Pallipedia accessed 17/08/2022).

Priority Needs

Priority needs include the issues, problems, and requirements that the affected population (in this case, the Rohingya and host communities) identifies as most important to them.

Supplementary Feeding

Supplementary feeding refers to the provision of food to the nutritionally or socially vulnerable aside from the general food distribution to treat or prevent malnutrition.

There are two types of supplementary feeding programmes. Blanket supplementary feeding programmes target a food supplement to all members of a specified at-risk group, regardless of whether they have moderate acute malnutrition or not. Targeted supplementary feeding programmes provide nutritional support to individuals with moderate acute malnutrition (UNICEF 04/2012).

Upazila

An upazila is an administrative region in Bangladesh functioning as a sub-unit of a district (Panday 26/06/2018).

VOUCHERS**Commodity Voucher**

Commodity vouchers entitle the holder to a fixed quantity and quality of specified goods or services at participating vendors. Commodity vouchers share some similarities with in-kind aid in that they restrict and specify the assistance people receive (EC 26/02/2019).

E-Vouchers

An e-voucher is a card or code electronically redeemed at a participating distribution point.

E-vouchers can represent cash or commodity value and are redeemed using a range of electronic devices. E-vouchers are similar to value vouchers, except a value voucher does not have to be electronic (CALP accessed 17/08/2022).

WFP's regular food assistance in Cox's Bazar provides every refugee family in the camps with an e-voucher, topped up with a monthly allowance of USD 12 per person per month. Refugees can purchase their preferred foods directly from a network of 22 outlets in the camps managed by Bangladeshi retailers (WFP 10/01/2022).

Value Vouchers

A value voucher has a denominated cash value and can be exchanged with participating vendors for goods or services of an equivalent monetary cost. Value vouchers provide relatively greater flexibility and choice than commodity vouchers but are still necessarily restricted as they can only be exchanged with designated vendors (CALP accessed 17/08/2022).

ANNEX 2 - REVA J-MSNA COMPARISON TABLE 1/2

ASSESSMENT (USE THE REFERENCES WE HAVE GIVEN IN THE REPORT)	DATES OF DATA COLLECTION	TIME TAKEN TO COLLECT THE DATA	NUMBER OF QUESTIONS/ INDICATORS	SAMPLE SIZE	DATE OF PUBLICATION	TIME BETWEEN DATA COLLECTION AND PUBLICATION (PROXY FOR TIME TAKEN FOR ANALYSIS)	REMARKS
REVA 2017	November 2017	not clear	6	2,046 household surveys	9 August 2018	9 months	
REVA 2018	20 October to 4 December 2018	46 days	5	2,593 household surveys	June 2019	6 months	
REVA 2019	December 2019	not clear	7	2,701 household surveys, 19 FGDs	20 April 2020	4 months	
REVA 2020	7 November to 3 December 2020	27 days	5	2,702 household surveys, 13 FGDs	15 April 2021	4 months	
REVA 2021 (technical report)	12 October to 22 November 2021; 24–27 January 2022	46 days	5	3,686 household surveys, 19 FGDs	30 June 2022	5 months	
J-MSNA Rohingya 2018	2–31 July 2018	30 days	8	3,171 household surveys	31 July 2018	0 days	Published on ReliefWeb on 19 December 2018; original published date was mentioned as 31 July 2018.
J-MSNA Rohingya 2019	5 August to 15 September 2019	41 days	15	3,418 households	12 March 2020	6 months	
J-MSNA Rohingya 2020	27 July to 27 August 2020	32 days	18	836 households, 40 KIIs	6 May 2021	9 months	All data was collected remotely over the phone.
J-MSNA Rohingya 2021	12–26 August 2021; 21–29 September 2021	24 days	16	3,683 households, 20 FGDs	8 August 2022	11 months	Quantitative data was collected remotely over the phone; qualitative data was collected in person.
J-MSNA Host 2018	11 November to 6 December 2018; 18–25 March 2019	34 days	5	2,881 household Surveys, 22 FGDs	31 March 2019	6 days	Published on ReliefWeb on 16 October 2019; original published date was mentioned as 30 March 2019.
J-MSNA Host 2019	7 August to 9 September 2019	33 days	6	1,321 households	12 March 2020	6 months	
J-MSNA Host 2020	28 July to 30 August 2020	34 days	9	911 households, 23 KIIs	6 May 2021	9 months	All data was collected remotely over the phone.
J-MSNA Host 2021	12 July 2021; 18 August 2021; 21–29 September 2021	16 days	7	1,118 households, 20 FGDs	8 August 2022	11 months	Quantitative data was collected remotely over the phone; qualitative data was collected in person.

ANNEX 2 - REVA J-MSNA COMPARISON TABLE 2/2

		Assesments												
SECTORS	INDICATOR	REVA 2017	REVA 2018	REVA 2019	REVA 2020	REVA 2021 (TECHNICAL REPORT)	J-MSNA ROHINGYA 2018	J-MSNA ROHINGYA 2019	J-MSNA ROHINGYA 2020	J-MSNA ROHINGYA 2021	J-MSNA HOST 2018	J-MSNA HOST 2019	J-MSNA HOST 2020	J-MSNA HOST 2021
Food	FCS	x	x	x	x	x								
	FCS of female- vs. male-headed households	x	x	x		x		x	x			x		
Livelihood	Main source of income	x	x	x	x	x	x							
	Changes in economic vulnerability level		x	x	x	x								
	Changes in overall vulnerability level		x	x	x	x								
Health	Usage of different health facilities						x	x	x	x				
	Households seeking treatment							x	x	x		x	x	x
	Barrier in accessing health facilities			x			x	x	x	x		x	x	x
Shelter	Shelter as a priority need							x	x	x	x		x	x
	Cooking fuel						x	x	x	x		x	x	x
	Consistent need for light						x	x	x	x				
WASH	Usage of piped water						x	x	x	x				
	Issues accessing water	x						x	x	x				
	Issues accessing WASH facilities			x					x	x	x			x
	Soap availability						x	x	x	x	x		x	x
	Access to menstrual hygiene items									x	x			
Protection	Protection situation in terms of Child protection and GBV							x	x				x	
	Point of contact							x	x	x				
Education	Quality of education	x							x					
	Challenges in accessing education	x			x				x	x	x	x	x	x
Nutrition	Satisfaction with nutrition services							x	x	x		x	x	
Communication	Participation in CFM						x	x	x	x				
	Provision of information							x	x	x			x	