The Shadow Pandemic:

Gender-Based Violence among Rohingya refugees in Cox's Bazar

International Rescue Committee

Glossary

CCSAS	Clinical Care for Sexual Assault Survivors
CiC	Camp-in-Charge
DFID	Department for International Development
EMAP	Engaging Men through Accountable Practice
GBV	Gender-Based Violence
GBVIMS	Gender-Based Violence Information Management System
GoB	Government of Bangladesh
IASC	Inter-Agency Standing Committee
IMS	Information Management System
IPV	Intimate Partner Violence
IRC	International Rescue Committee
IWC	Integrated Women's Centres
JRP	Joint Response Plan for the Rohingya
NGO	Non-Governmental Organisation
PTSD	Post-Traumatic Stress Disorder
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
UN	United Nations
UNFPA	United Nations Population Fund
WGSS	Women and Girls Safe Spaces
WHO	World Health Organisation
WPE	Women's Protection and Empowerment

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Front cover: A view over Ukhiya camp in Cox's Bazar where thousands of Rohingya live after fleeing violence in Myanmar. *Habiba Nowrose/IRC*

Executive Summary

Gender-Based Violence (GBV) is a pandemic which violates human rights across communities around the world. Rohingya women and girls who fled to Bangladesh following severe rights violations enacted upon them by the Myanmar military in 2017 continue to live with the threat of violence in Cox's Bazar. The Government of Bangladesh and international responders have worked tirelessly to rapidly scale up humanitarian assistance to meet the needs of Rohingya refugees, including women and girls, and significant strides have been made. However, data from the International Rescue Committee's (IRC) programmes demonstrates that women and girls continue to live with the threat of violence in Cox's Bazar – and the risks they face are likely to be compounded by the spread of COVID-19 and steps taken to mitigate against it.

This report uses data collected between July and December 2019 from the IRC's women's centres and health programme sites in 19 camps across Cox's Bazar to assess trends in rates of GBV. The IRC's analysis shows that even before the COVID-19 crisis, reported rates of GBV in the camps were at least in-line with global levels despite the enormous social, cultural and psychological barriers faced by women and girls when reporting incidents. With the first cases of COVID-19 now officially recognised in the Rohingya camps and lockdown measures often leaving women and girls trapped in domestic settings, rates of GBV will only increase – as has been seen around the world, from the UK to China to Brazil, where domestic violence drop-in centres have seen cases rise by up to 50 percent since lockdown.[i] Yet at the same time, IRC protection monitoring data shows there has been a 50 percent decrease in the number of women and girls seeking GBV services in Cox's Bazar – a marker of the further restrictions on mobility, availability of information and other barriers to reporting that Rohingya women and girls face during lockdown.[ii]

The report offers an assessment of the long-term drivers behind these GBV trends, as well as the effect that the spread of COVID-19 will have on the ability of humanitarian agencies to provide programming and services in the camps. By exploring the key drivers, the report demonstrates the barriers Rohingya women and girls face in reporting incidents of GBV, accessing services and seeking justice.

The levels of gender-based violence experienced by Rohingya women and girls provides a stark illustration of the global shadow pandemic that COVID-19 has exacerbated. In Bangladesh, and in other contexts of displacement, governments – with the support of international donors, UN agencies, and national and international NGOs – should take immediate action to deliver a surge in cross-sector effort to ensure that women and girls are safe, protected, and supported to recover and thrive.

Summary of recommendations:

- The Government of Bangladesh to **designate all critical GBV services as essential** and work with implementing agencies to adapt services in light of social distancing restrictions, to allow for continuity of service provision throughout the pandemic.
- Donors to **triple funding for GBV prevention and response activities** to meet existing needs and expand programming to address unmet needs, ensuring funding is made available for prevention activities that engage and work with men and boys to address harmful gender norms and mandating the use of sex and age-disagreggated data.
- UN agencies and NGOs to **support women and girls to be at the forefront of participation in decision-making processes during the COVID-19 response,** including in the design and delivery of programmes to improve community engagement and trust in mitigation interventions.
- All actors involved in the response should continue to **address site-management issues, including the lack of lighting, that put women and girls at risk of GBV** through the provision of adequate funding to relevant operational partners.

I. Background

More than two years have passed since over 740,000[iii] Rohingya fled violence in Rahkine that the United Nations (UN) said had the "hallmarks of genocide" to seek protection in Bangladesh. Today, almost 900,000 refugees, 52 percent of whom are women and girls, live encamped in the district of Cox's Bazar.[iv] Having witnessed or experienced what the UN referred to as "inhuman treatment… [and] sexual violence"[v] as well as the use of rape as a weapon, many Rohingya women and girls continue to suffer from Gender-Based Violence (GBV) today. Studies amongst refugees in Cox's Bazar "indicate high prevalence of symptoms typically associated with posttraumatic stress disorder (PTSD) and depression".[vi] The IRC's research and expertise shows that far more must be done to address this epidemic of violence against women and girls.

The Government of Bangladesh's (GoB) willingness to host the Rohingya population at a time when other wealthier countries neglected their refugee hosting commitments must be commended. The Government and international responders to the crisis have worked tirelessly to rapidly scale up humanitarian assistance in Cox's Bazar to meet the needs of Rohingya refugees, including women and girls. By the end of 2019, almost 400,000 refugees had been reached with GBV services, of which over 280,000 were women and girls. In addition, 2,744 humanitarian actors have been trained and 80 dedicated Safe Spaces for women and girls are operational, providing essential and lifesaving services and information.

However, the IRC's data shows that the protection risks facing women and girls continue to outstrip this impressive scale up in service provision. **Data from 19 centres operated by the IRC across 19 camps where GBV screening is undertaken[1] demonstrates that at least one in every four women or girls screened was a survivor of GBV between July – December 2019.[2] As stated in the 2020 Joint Response Plan, given the barriers to reporting GBV in Cox's Bazar, "the recorded cases are likely to represent only a small fraction of the overall number"[vii], and will be increased by COVID-19.[3]**

The arrival of COVID-19 in Cox's Bazar poses a major threat to refugees. With a population density of approximately 40,000 people per km^2 in Kutupalong and the surrounding expansion camps,[viii] social distancing is almost impossible, and hygiene interventions are challenging. For women and girls, in addition to the health risks, the virus drastically compounds the existing risks of GBV. The UN Secretary-General stated that women and girls will be hit hardest by the COVID-19 pandemic,[ix] while according to UNFPA, an estimated 15 million additional cases of GBV will occur for every three months of lockdown due to COVID-19.[x] In March, IRC programmes reported a 50 percent decrease in the number of women accessing Women's Protection and Empowerment (WPE) case management services owing to isolation and fear since the onset of COVID-19, meaning an upsurge in support will be needed once movement restrictions are lifted.

This report calls for a surge in cross-sector effort, particularly in light of the exponential risks posed by COVID-19, for new funding for specialised GBV expertise, and a boost in capacity to ensure that the Rohingya women and girls of Cox's Bazar are safe, protected, and supported to recover and thrive.

Above: A Rohingya woman carries her child through Kutupalong camp as a storm approaches. *Maruf Hasan/IRC*

[1] The purpose of the GBV screening tool is to support survivors to safely and confidently disclose their experiences and link them to available services.

[2] GBV is often underreported for a variety of reasons including stigma, fear, threat of retribution, and lack of access to quality GBV response services. This number is only reflective of women who sought support from the IRC and provided consent for their number to be shared.

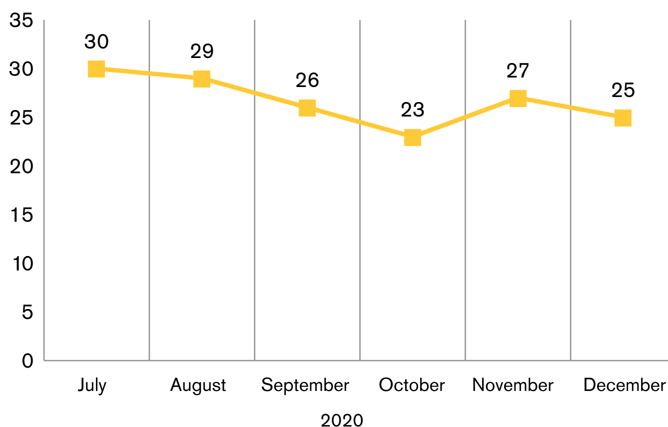
[3] Reported numbers of GBV do not capture the entirety of violence against women and girls. Stigma, fear, isolation and fear of being killed often prevent women and girls from seeking services after an incident of GBV which leads to underreporting. (GBV Guidelines). The actual number is higher.

II. GBV Trends in Cox's Bazar

The data used in this report was collected independently at IRC Women and Girls Safe Spaces and partner facilities in coordination with the GBV-Information Management System (GBVIMS) under safe and ethical data collection standards at the point of service provision. Agencies providing GBV case management collect data through the GBV information management system (i.e. women and girls who have received GBV case management), whereas the IRC conducts direct GBV screening of all women who consent through its health providers at the WGSS and health facilities and the GBVIMS – providing insight into the risks facing women and girls.

Between July and December 2019, prior to the COVID-19 crisis, 21,517 women and girls were screened at IRC women's centre and health programme sites in 19 camps in Cox's Bazar. While the data offers insights into the crisis of GBV in the camps it must repeatedly be noted that due to the risks women and girls face in reporting incidents of GBV, fewer than half of those who attended IRC programme sites consented to screening. The IRC therefore assesses that these findings are a significant underrepresentation of the scale of GBV in the Rohingya camps. However, even the limited trends found within this dataset demonstrate widespread violence against women and girls, and gaps in support for survivors.

Percentage of women and girls screened who reported incidents of GBV



On average, prior to the COVID-19 pandemic, 27 percent of Rohingya women and girls screened at IRC programme sites reported experiencing GBV each month.

In total, of the women and girls who consented to discuss their experiences:

- 57 percent reported having experienced physical assault
- 22 percent reported denial of resources, opportunities and services by a domestic partner
- 16 percent reported psychological or emotional abuse
- 3 percent reported rape
- 2 percent reported other types of sexual assault

The process of seeking support following an incident of GBV in contexts of displacement, even in a private setting, is likely to create safety concerns for women and girls and heightens the risk of reprisals and stigma. Of those who disclosed an incident of GBV:

- 93.33 percent accepted psychosocial services
- 37 percent consented to legal counseling to seek justice either through community or state mechanisms
- 20 percent accepted legal services

All women and girls screened at IRC women's centres and health programming sites who reported sexual assault accepted Clinical Care for Sexual Assault Survivors (CCSAS) services provided by the IRC.

Above: An IRC worker stands outside of an IRC health facility in Teknaf camp. *Habiba Nowrose/IRC*

The majority of GBV in Cox's Bazar, 81 percent, is perpetrated by intimate partners, known as Intimate Partner Violence (IPV).[xi] IPV is a form of domestic violence which consists of, but is not limited to, physical and sexual abuse, emotional violence, and denial of resources. Most survivors of IPV report experiencing multiple types of GBV. However, the particular prevalence of physical assault, with over 50 percent of GBV survivors reporting incidents, reflects the ongoing dangers of deeply embedded patriarchal norms in Rohingya society, and the dangers women and girls face in the home – dangers that are significantly increased under COVID-19 lockdown.

Global scale of GBV: While GBV is an acute threat within the Cox's Bazar Rohingya community, it is far from being a phenomenon unique to refugee response in Bangladesh. The DFID funded *What Works* project, under which the IRC conducted research, found the global prevalence of sexual violence among refugees and displaced persons in humanitarian crises is estimated to be 21.4 percent, suggesting that approximately one in five women who are refugees or displaced by an emergency experience sexual violence.[xii] At the core of the epidemic is the unequal power dynamic between men and women.[xiii] Gendered inequality and its impacts are magnified during humanitarian and refugee crises, where existing trauma and sexism, insufficient protection services, and disruption of regular support networks leave women and girls exposed to a higher risk of GBV – which simultaneously shrinks their freedom and independence. The onset of COVID-19 further magnifies these risks.

In Cox's Bazar, the IRC runs an integrated health and protection programme. The IRC supports five Integrated Women's Centres (IWCs) across 5 camps[4] and a Comprehensive Women's Centre, each of which offer GBV case management, psychosocial support, activities for adolescent girls and basic Sexual and Reproductive Health (SRH) services including GBV screening, clinical care for sexual assault survivors (CCSAS), and family planning. The IRC's facilities also promote general information sharing and outreach through community engagement and awareness raising, mobilising community activists (teachers, religious leaders and elders) to address harmful gender power dynamics. In response to a woman or girl surviving GBV, the IRC provides GBV case management services which offer individualised care to recover, heal and connect the survivor to support mechanisms. When appropriate, the health team provides CCSASs. Dignity kits are provided to women and girls to reduce the risks they face in the community. The IRC's 57 facilities in Cox's Bazar employ over 400 staff members, 50 percent of whom are women, with 390 Bangladeshi nationals and 10 international staff.

Above: Dilshad manages the IRC's Women's Centre in Teknaf, Bangladesh in Cox's Bazar. Here, Rohingya women and girls learn skills, build confidence and understand their rights. *Habiba Nowrose/IRC*

[4] The IWC offers a space where women can safely and confidently disclose incidences of GBV and start the healing and ultimate recovery from the trauma they faced with the support of case workers. It also offers a place where they can form social networks with other women and access information about services available to them in the camps.

III.The drivers of GBV trends

To address GBV risks in Cox's Bazar it is critical to first understand the drivers, which are explored in this section.

Restrictive social norms: Traditional social norms amongst the Rohingya population mean that women and girls often do not leave their homes. The cultural practice of purdah, in which women and girls are screened from men and strangers by a curtain at home or a veil in public, further restricts their presence.[xiv] When women do appear in public – typically those who live in female-headed households – or choose not to wear a veil, the risk of harassment by men is significantly higher. Female Rohingya NGO volunteers have frequently reported harassment while conducting their work in public spaces. For young girls, cultural norms can mean that following instances of rape or child pregnancy, survivors are forced to marry the perpetrator to avoid shame to the girl's family.

Lack of refugee livelihoods in Cox's Bazar: The IRC's research shows that women's economic empowerment can work towards combating the effects of restrictive gender norms when coupled with effective GBV response and prevention. When women's contributions to the economy are supported and accepted in a way that women can both shape the economy and take part in it, they have greater control over financial resources, are less at risk of exploitation, and have more power to challenge discrimination.[xv] Higher income for a household lowers the exposure of women to be exploited by men through early and forced marriage and commercialized sexual exploitation. Yet Government of Bangladesh policy forbids Rohingya refugees from working, forcing many men and women into a limited number of informal sector jobs where women face risks of harassment and exploitation.

Data gathered in Cox's Bazar demonstrates that due to restrictions on refugee employment, the vast majority of perpetrators of GBV (75 percent) are unemployed. IRC analysis further shows that the lack of livelihood opportunities for men has disrupted traditional social norms around the male head of household as the provider and is likely to exacerbate already high rates of IPV and physical assault[5] – a trend that is further compounded when female partners find livelihoods opportunities. A recent assessment carried out by the IRC in Cox's Bazar shows that the loss of status and unfulfilled expectations over traditional domestic roles can exacerbate the already known risk of male violence in the home – both because men are at home more, and because their traditional roles are changing.[xvi] Livelihoods support programmes for Rohingya women must be delivered alongside programmes to tackle the discriminatory social norms that prevent women from capitalising on them.[xvii]

Challenging gender norms: preventing GBV.
The root of GBV is gender inequality between women and men which manifests as deep-rooted sexism within the society. Working with men and boys, with guidance from women and girls, through prevention and risk reduction programming can help tackle the negative outcomes of restrictive and sexist social norms on women and girls. In the first half of 2019, 232,466 Rohingya were reached through GBV sub-sector awareness raising and community mobilisation programmes – however only 22 percent were men and boys.[xviii] Reaching men and boys requires consent from involved parties, and such interventions can take time. Social change programmes such as the IRC's Engaging Men through Accountable Practice (EMAP)[xix] work with men to foster transformational attitude and behavioural changes guided by the voices of women and girls. Community outreach and dialogue with Rohingya community leaders to challenge destructive or damaging behaviour[xx] also plays an important role. Other programmes, such as the IRC's Girl Shine[xxi] curriculum, work with both adolescent girls and their parents/care-givers to protect and empower girls as well as support their safety and agency for self-determination. Prevention and transformation of gender norms are further tackled by sessions for women and girls on GBV and Sexual and Reproductive Health-related topics, which are held on a weekly basis in the IRC's Integrated Women's Centres, with feedback from participants in coordination with IRC staff.

Above: Children draw and play in a safe space in the IRC's Women's Centre, Teknaf camp. *Habiba Nowrose/IRC*

[5] IPV is not caused by male unemployment. It is caused by unequal power of men over women (for instance, female unemployment doesn't lead to IPV).

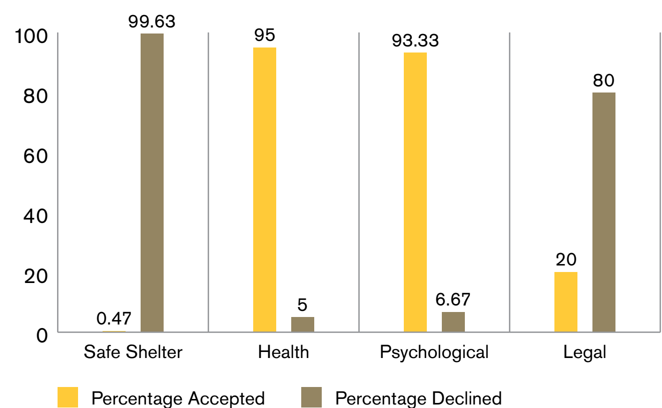
Above: Yasmin and her 3-month-old baby wait to be seen by doctors at an IRC health centre. *Habiba Nowrose/IRC*

Access to justice in Cox's Bazar: Structural and cultural barriers to accessing justice mechanisms in the Cox's Bazar camps offer an explanation for the low percentage of survivors – 20 percent – willing to accept legal services after having experienced GBV. In addition, justice mechanisms themselves often drive further violence. To access Bangladesh's state justice system, survivors first have to report their incident to their local Majhi, a community representative who is typically male, before their case is then brought to the Camp-in-Charge[6] (CiC), a GoB official who will record their testimony and decide whether or not to refer them to the state system (through the police). This referral requires a medical examination in a Bangladeshi hospital to ascertain if GBV has occurred, even if screening has already been carried out in the camp, contributing to re-traumatisation of women and girls.

In practice, CiCs typically prefer to address cases within the camps,[xxii] and as a result, the majority of justice complaints are heard through community-led systems that involve mediation: a process usually led by male community leaders including imams, majhis, or the CiC, all of whom have limited – if any – technical capacity to play this role. Mediation sessions often involve the attribution of blame or shame to GBV survivors due to the societal belief that women hold responsibility for the violence they face.[xxiii] In addition, following incidents of IPV, cases are unlikely to be reported to police or state justice because the perpetrator is typically only given a "warning" by the CiC, which, according to survivors the IRC spoke to, often leads to a significant risk of revenge violence by the original perpetrator or another relative, and in some cases the killing of female survivors.

Confidentiality issues in reporting: The majority of women and girls cannot independently access women and girl-friendly spaces that offer clinical management of rape services or health services, or report cases of GBV to the police without a male family member accompanying them to the services. Furthermore, there have been breaches of minimum IASC standards – for example on data confidentiality – due to untrained staff being responsible for programme reporting and sharing information about survivors with third parties, as well as during interrogation by majhis and CiCs. Such breaches or lack of confidentiality can result in further violence occurring in retribution for reporting. The below table demonstrates that while the majority of women and girls – 80 percent – decline legal assistance services which require public acknowledgment of GBV, over 90 percent accept psychosocial services – which are conducted privately and confidentially – when offered:

Services offered at women's centres



[6] The CIC is the only person mandated to inform the police

IV. Effects of COVID-19 on GBV in the camps

As of 8th June 2020, Bangladesh has 68,504 confirmed cases of COVID-19, of which 30 are in the Rohingya camps, although testing remains limited. The first officially recorded case of COVID-19 infection among the Rohingya in Cox's Bazar occurred on 14th May 2020 and the first death on 31st May 2020,[xxiv] though the virus was likely to have been present in the Rohingya population even earlier. Like conflict, epidemics and pandemics exacerbate pre-existing gender inequalities, and measures to contain transmission, such as the government-enforced lockdown of refugee camps in Cox's Bazar, disproportionately impact women and girls.

Despite the fact that many GBV services for refugees in Cox's Bazar continue, barriers to accessing programming for GBV response and prevention have increased because of COVID-19 and restrictions placed on movement of refugees. Individualised GBV case management services are still operational to ensure survivors have support during COVID-19. Volunteers also continue to conduct door-to-door awareness raising. However, structured GBV prevention activities like Raising Voices's SASA![xxv] and the IRC's Engaging Men through Accountable Practices (EMAP)[xxvi] programmes are closed, having been categorised as non-essential by the government. Closure of GBV prevention services will have a secondary impact on information provision as well as protection. Findings from IRC women's centres indicate that more women accessed sexual and reproductive health information in women and girls safe spaces than in clinics, due to having trust and confidence in those centres. Yet since the government imposed lockdown, fewer women and girls are accessing women and girls centres. As a further consequence, access to emergency contraceptives, menstrual hygiene management, deliveries, and CCSAS may be restricted.

Rumours that refugees will be screened for COVID-19 and placed under quarantine if they access services have also begun to prevent many women and girls from attending COVID-19 prevention awareness sessions, and undermine the opportunities for women and girls to participate in COVID-19 response design. This trend of misinformation is compounded by the current restrictions on refugee access to telephone and internet networks, which severely restrict information provision and communication with refugees. IRC protection monitoring data has already shown a 50 percent decrease in the number of women and girls accessing WPE services since COVID-19 lockdown measures were put in place.[xxvii] Such experience reinforces the IRC's lessons from the Ebola response in the Democratic Republic of Congo (DRC) on the important role existing frontline responders can play in community engagement and information provision based on long-standing experience of working with communities. However, the most immediate effect of the pandemic for women and girls in Cox's Bazar results from the lockdown of camps, which will increase levels of intimate partner violence.[xxviii] In North Kivu, DRC, during the Ebola crisis, women experienced higher rates of intimate partner violence and elevated risk of sexual harassment.[xxix] IRC monitoring already shows an increase in fear of GBV amongst refugees in the camps.

Above: An IRC paramedic screening for COVID-19 checks a Rohingya woman's temperature. *Maruf Hasan/IRC*

V. The response so far – significant progress, but room for improvement

Rapid investment of resources since August 2017 has resulted in significant progress in addressing the humanitarian and protection needs of Rohingya women and girls. The 2018 and 2019 Joint Response Plans (JRP) provided an important foundation for the GBV response and have registered a number of successes, including improved access to services for survivors, expansion of GBV prevention programming, and establishment of standardised service delivery among agencies based on GBV standards. The new 2020 JRP marks a further positive step forwards with a clear and specific objective on improving "access to quality survivor-centred services by responding to individual needs, preventing and mitigating GBV risks, and supporting women, girls and survivors of GBV".[xxx]

However, gaps in services and risks for women and girls continue, illustrating the need for further investment and international support to ensure women and girls are protected from harm and supported to recover and thrive.

- Relatively simple site management and design issues continue to put women and girls at risk. Female Rohingya respondents to an IRC-led community dialogues discussion stated that they were afraid to go to the bathroom at night-time, citing insufficient lighting in public spaces.[xxxi] This is further corroborated by the 2020 JRP, which noted that 50 percent of women interviewed mentioned that inadequate lighting in latrines and water facilities made them feel unsafe at night.[xxxii] According to GBVIMS data, sexual assault happens more often at night than any other time, when women and girls are accessing these services with limited lighting.[xxxiii]

- Barriers to information provision continue to affect the response. The 2020 JRP notes that 57 percent of women interviewed were unable to identify any GBV service points in the camps.[xxxiv] Limits in available information are further compounded by current restrictions on cellular and internet access in the camps, which also leaves Rohingya without a clear understanding of the COVID-19 outbreak and how to limit exposure.

- Funding shortfalls also impact the response. In 2019, the JRP targeted 610,117 refugees under the GBV pillar[xxxv] at a cost of 23 million dollars, and yet only 46 percent of the funding request was fulfilled.[xxxvi] In 2020, the JRP sets out a GBV response population target of 558,671 (459,319 refugees and 99,298 from the host community) with a funding request of 24 million dollars.[xxxvii] The sector appeal is currently 3.8 percent funded.[xxxviii] The levels of GBV experienced amongst the refugee population signify that the needs amongst the population are significantly greater than the target would suggest, indicating a need to not only fulfill existing requests, but also substantially increase funding for the sector. As the effects of the COVID-19 pandemic worsen in Cox's Bazar, and increased pressure is placed on donor funding, resources for GBV-focused programmes may decline or be diverted at the same time that women and girls are experiencing GBV at higher rates.

- Only four donor countries referenced Bangladesh in their 2018 Call to Action Partner Progress Reports, demonstrating limited will and action in international support. A globally unified response is required to tackle GBV in Cox's Bazar.

A Rohingya IRC volunteer stands inside the IRC's Integrated Women's Centre in Teknaf camp. *Habiba Nowrose/IRC*

Recommendations

GBV remains a major concern in Cox's Bazar. Given the multiple factors which compound and increase women and girls' risk of GBV while limiting their access to services, the response requires a multi-pronged approach at every level. The addition of COVID-19 to these factors has increased the urgency of an already critical situation. The IRC therefore recommends that:

The Government of Bangladesh:

1) Designate critical GBV services as essential (including Clinical Care for Sexual Assault Survivors, psychosocial support, and group sessions) to allow for continuity of GBV service provision throughout the COVID-19 response, by allowing implementing agencies to adapt programmes with social distancing and infection prevention control measures, guided by operating procedures agreed with the WHO and the GBV sub-sector. Where possible, humanitarian agencies should adapt and provide prevention services using approaches such as and mobile loud speakers and mobile phones.
2) Working with international donors, take steps to support refugee women's access to small scale livelihoods in the camps (including home-based enterprises and value chain activities that could be preferable for women), enabling them to provide for their families, gain economic independence, and avoid negative coping mechanisms which harm girls, such as child, early and forced marriage. Such interventions should emphasise a gender transformative approach in programming, actively tackling social norms and skill gaps to enable women to engage in economic opportunities without fear of harassment and violence.
3) Increase refugee GBV survivors' access to justice services by reviewing and updating GBV reporting policies to provide access to courts of law, police and other designated legal structures in a secure, confidential and safe manner, including the removal of requirements that necessitate repeated screening and medical examination. Working with NGOs, explore the possibility of equipping each CiC office with a gender/GBV expert to provide technical support to handle cases of GBV appropriately. Work with national and international NGOs to address gender norms and traditions that put those reporting GBV at risk of reprisal.
4) Work with humanitarian agencies to establish inclusive and representative camp leadership structures with equal representation for women and men, to replace the current mahji system.
5) Restore all refugee access to mobile telephone and internet networks to enable women and girls to receive information on GBV service provision and reliable information on prevention and response to COVID-19.

Donors:

1) In line with the IRC's global GBV funding call, triple funding for GBV prevention and response activities[xxxix] in order to meet existing needs and expand programming to address unmet needs, particularly in light of the anticipated spike in incidents from COVID-19, through the delivery of services that meet IASC GBV Minimum Standards. Ensure appropriate funding is made available for prevention activities that engage and work with men and boys to gradually address harmful gender norms.
2) Working with the Government of Bangladesh, integrate prevention efforts and services to respond to violence against women and girls into the COVID-19 response plan to meet the needs of refugees and, where appropriate, host communities.
3) Funding should not be over-indexed to the COVID-19 response at the expense of existing needs. Funding to operational partners should be timely, flexible, and channelled to trusted frontline responders with the capacity to uphold and expand life-saving programming, including GBV interventions.
4) Donors who are members of the Call to Action should commit to implement outcomes of the Call to Action Road Map (2021-2026) in the Rohingya response in Cox's Bazar, Bangladesh, including mandating the use of sex and age disaggregated data of at-risk populations.

UN agencies and NGOs:

1) Support women and girls to fully participate in decision-making processes including in the design and delivery of programmes in the COVID-19 response. Without enhanced consultations targeting women, their needs, preferences and concerns are likely to be overlooked – for example, by failing to consider their challenges in accessing information.
2) Further build the capacity of GBV national and international responders, including local women rights groups in Cox's Bazar through training, mentoring and technical support to: deliver services that meet IASC GBV Minimum Standards; mainstream women's and girl's protection concerns into wider sectoral programming; train healthcare workers to identify signs of GBV and refer to appropriate services; and support women to take leadership roles in the GBV response.
3) Apply the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies as guiding principles in all programming across all sectors to enhance women and girls' protection.
4) Continue to advocate with the Government of Bangladesh to designate all GBV activities as essential during the COVID-19 response.

All actors involved in the response:

1) Under the leadership of UNFPA, assess progress and gaps in the GBV response to inform a five-year GBV Action Plan (2021-2025) to meet the needs of refugee and host communities. The strategy should take into consideration the scope for contribution to the Sustainable Development Goals (SDGs 5 and 16 in particular).
2) Continue to address site-management issues, including the lack of lighting, that put women and girls at risk of GBV through the provision of adequate funding to relevant operational partners.

Above: An IRC Rohingya volunteer stands outside the IRC Women's Centre in Teknaf camp. *Habiba Nowrose/IRC*

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