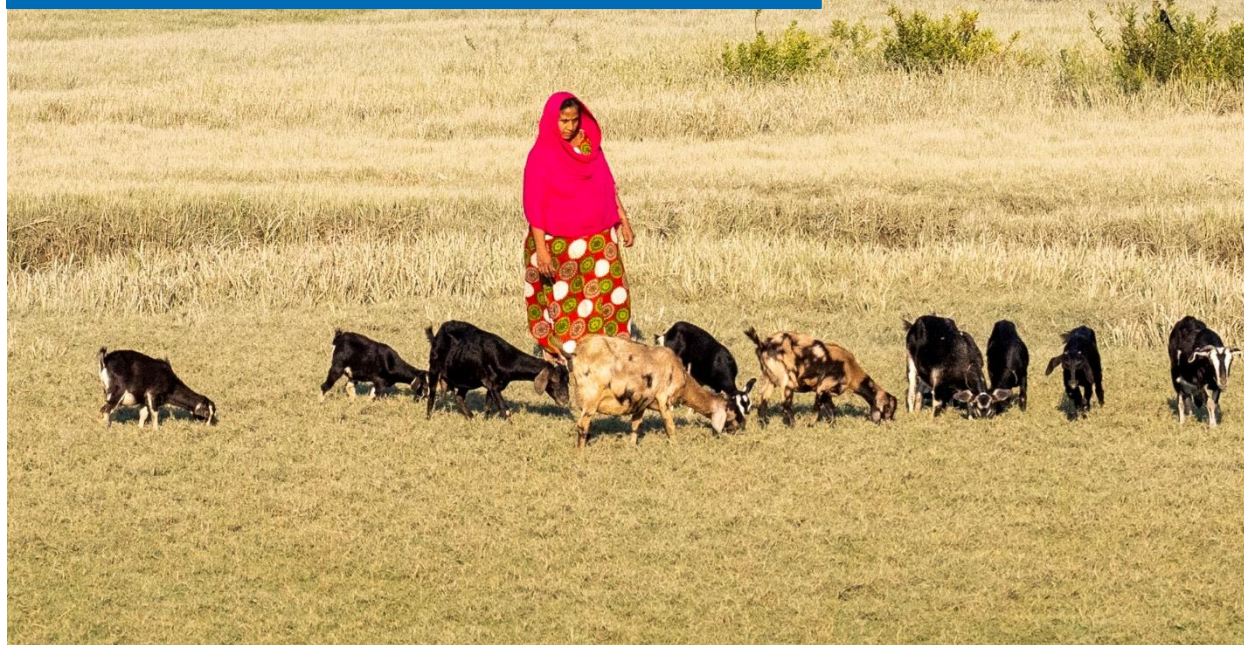


COX'S BAZAR, BANGLADESH

Joint Multi-Sector Needs Assessment (J-MSNA)

Host Community

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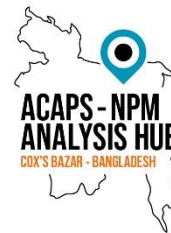


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EXECUTIVE SUMMARY

The District of Cox's Bazar, located in southern Bangladesh, has some of the poorest living conditions in the country.¹ At the same time, over the last four decades, in successive waves, it has received Rohingya refugees fleeing from targeted violence and persecution in Rakhine State, Myanmar. Since August 2017, an estimated 745,000 Rohingya refugees have fled to Cox's Bazar District, where approximately 860,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas.² Needs among the host communities in Ukhiya and Teknaf arise mainly from existing development challenges, but may have been compounded by the refugee influx.³ With the refugee population being almost double the host community population in the two upazilas,⁴ the massive increase in population density following the influx, coupled with the pre-existing lack of livelihoods, levels of poverty and vulnerability among the host community population, has led to tensions over labour competition, falling wages and price hikes of daily essentials. Perceived increases in crime, security concerns, and high pressures on the environment leading to deforestation and depleting water sources have further been reported as sources of tension.⁵ The outbreak of the COVID-19 pandemic and associated containment measures put in place nationwide on 22 March 2020 severely disrupted livelihoods among the host community populations, which is likely to have exacerbated pre-existing needs. As such, sustained assistance and effective prioritisation for 2021 will be essential to be able to meet persisting levels of need.

As the response has moved beyond the initial emergency phase, there is a continued need for up-to-date information on the needs and vulnerabilities of the host community, in order to inform the design and implementation of effective inter-sectoral programming. At the same time, an understanding of the impact of the COVID-19 outbreak and associated containment measures on household-level multi-sectoral needs, capacities and access to services will be essential for a full understanding of priority needs for 2021. Against this background, a Joint Multi-Sector Needs Assessment (J-MSNA) was conducted across host community populations to inform evidence-based strategic planning of humanitarian response activities by the Strategic Executive Group (SEG), the Inter Sector Coordination Group (ISCG) Secretariat, sectors, and sector partners. The J-MSNA further aimed to provide an analytical basis for the development of the 2021 Joint Response Plan (JRP). It built on previous MSNAs, in particular the [2019 J-MSNA](#) with the goal to facilitate an understanding of the evolution of needs and service gaps across time, and was implemented through the ISCG's MSNA Technical Working Group (TWG) of the Information Management and Assessment Working Group (IMAWG), which is led by the ISCG and comprised of the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration Needs and Population Monitoring (IOM NPM), ACAPS, and REACH. Sectors were actively involved in research design, preparations for data collection, and the discussion of results and analyses.

The J-MSNA targeted all host community households residing in Ukhiya and Teknaf Upazilas. Sectors covered included Food Security, WASH, Shelter and Non-food items (NFIs), Protection, including the Child Protection and Gender-Based Violence Sub-Sectors, Health, Education, Nutrition, and Communication with Communities (CwC). Both quantitative and qualitative data was collected. For the quantitative component, households were sampled from

¹ ACAPS, *Cox's Bazar: Upazila Profiles (September 2020)* (Cox's Bazar, 2020). Available [here](#) (accessed 23 November 2020).

² Inter Sector Coordination Group (ISCG), *Situation Report Rohingya Refugee Crisis, Cox's Bazar, Bangladesh, June 2020* (Cox's Bazar, 2020a). Available [here](#) (accessed 23 November 2020).

³ Inter Sector Coordination Group, *2020 Joint Response Plan, Rohingya Humanitarian Crisis, January – December 2020, Bangladesh* (Cox's Bazar, 2019). Available [here](#) (accessed 23 November 2020).

⁴ Bangladesh Bureau of Statistics, *Population & Housing Census-2011, National Volume-2: Union Statistics* (Dhaka, 2011).

⁵ ACAPS, 2020; ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA): Host Communities – In-Depth | August – September 2019* (Cox's Bazar, 2019). Available [here](#) (accessed 23 November 2020).

UNHCR survey data as well as UNHCR and IOM beneficiary databases, using a stratified probability-proportional-to-size (PPS) random sampling approach, with stratification at the upazila level and a PPS sampling approach at the union and ward levels, as well as by gender of respondent. Results are representative of the population included in the sampling frame, i.e. households living in the vicinity of UNHCR camps and/or being UNHCR/IOM project beneficiaries, registered with phone numbers and in areas with mobile reception, at the upazila level at a 95% confidence level and with a 5% margin of error. A total of 911 interviews were carried out between 28 July and 13 August 2020. Basic descriptive analysis was conducted, complemented by testing for statistically significant differences in outcomes between households of different socio-economic characteristics, and a comparison of 2019 and 2020 results, where possible. Qualitative key informant interviews (KIIs) were used to supplement quantitative data collection, contextualise and validate findings, and draw qualitative links between sectoral outcomes. A total of 23 KIIs were conducted with ward members between 20 and 30 August 2020.

Quantitative data collection was conducted remotely over the phone, while qualitative data collection was conducted both in-person and remotely. The remote data collection modality limited the type and quantity of information that could be collected and therefore the depth of analysis, and put constraints on the populations that could be included in the sampling frame. While the KIIs and a secondary data review, as well as the sampling approach, mitigated the impact of those constraints, results should be interpreted cognisant of possible gaps and biases, for instance resulting from the exclusion of sensitive topics from the household survey, phone ownership being slightly biased towards men and better educated households, as well as mobile reception being unequal across different areas. Lastly, while current levels of need have to be explained within the context of the COVID-19 outbreak and associated containment measures, it was beyond the scope of this assessment to analyse expected levels of need if the containment measures had not been put into place. The findings are therefore intended as an overview of existing levels of need and not as an evaluation of the lockdown or COVID-19 containment measures.

Key findings

The COVID-19 outbreak and associated containment measures severely disrupted income-earning among host community households, and compared to 2019,⁶ in particular needs related to food security, health-seeking behaviour, education and (child) protection increased. At the same time, households' capacity to meet their needs and cope with service gaps, including recurring ones, such as monsoon-induced shelter damage, has been considerably reduced. As a result, **households are increasingly adopting coping mechanisms, including crisis-level ones. Even following the lifting of the lockdown, this can be expected to be reflected in household levels of need and capacity to cope with those as well as possible future shocks in the near and medium term, with households that were already most vulnerable pre-COVID-19 likely to continue to also be most negatively affected by its secondary impacts.**

Needs prioritised by households included access to food (reported by 55% of households among their top three priority needs), access to cash (54%) and shelter materials (40%). This was followed by access to income-generating activities (IGAs) (30%) and access to clean drinking water (26%). Compared to 2019,⁷ especially the proportions of households considering access to food and access to IGAs priority needs (42% and 22% in 2019 – access to cash was not assessed in 2019) increased considerably, likely reflecting the impact of the COVID-19 outbreak on food security and livelihoods.

⁶ ISCG, 2019.

⁷ Ibid.

Certain needs and service gaps that had already existed pre-COVID-19 remained unchanged, while others were exacerbated. Similar to 2019,⁸ **roughly a quarter of households (24%) reported not having made any improvements to their housing in the six months prior to data collection despite having reported issues**, largely due to a lack of money to pay for materials and/or labour. Over 40% of households reported having used purchased and/or self-collected firewood as a source of cooking fuel in the four weeks prior to data collection, and **only 26% reported having used exclusively LPG.**

The majority of households reported accessing improved drinking water sources. However, **23% reported not having enough water** to meet all domestic needs and several KIs reported water quality to be an issue. In addition, sanitation and waste management remained problems, with **14% of households reporting adult household members sometimes practising open defecation** and **11% of households reporting often or sometimes finding visible waste in the vicinity of their accommodation.**

The COVID-19 outbreak and associated containment measures severely disrupted income-earning and considerably reduced households' levels of income compared to pre-COVID-19 levels. Likely linked to the reduced levels of income, by July, **Food Consumption Scores (FCS) had dropped considerably** compared to last year, with a doubling in the proportion of households with a poor FCS from 4% to 8%, and a drop in acceptable FCS from 72% to 43%. The overall high proportion of households reporting having adopted food-based coping strategies in the seven days prior to data collection due to a lack of food (76%) is further indicative of **food shortages and consumption gaps.**

In addition, **overall health outcomes may have been negatively affected by the impact of the COVID-19 outbreak on health-seeking behaviour**, with the proportion of individuals reported sick enough to require medical treatment having dropped from 31% in 2019 to 14% in 2020. This is likely to reflect a drop in the proportion of individuals that sought treatment when they should have, and thus a reduction in health-seeking behaviour. Pre-existing barriers to seeking treatment, such as distance to health facilities and a lack of money to seek treatment, may have been compounded by health centres having closed and the number of health staff having been reduced at the start of the lockdown.

Moreover, **the proportion of households with pregnant/lactating women (PLWs) reporting PLWs to be enrolled in nutrition-feeding programmes remained low (12%), as did the proportion of children aged 6 to 59 months reportedly enrolled in nutrition-feeding programmes (15%).** This is likely linked to more limited nutrition programming in host communities compared to camps, but also to low levels of awareness or understanding of nutrition services and their benefits.

School enrolment rates also remained low, with 40% of individuals aged 4 to 24 reportedly not having attended any type of formal schooling for at least four days a week in the 30 days prior to school closures in mid-March due to the COVID-19 outbreak. Less educated households and those with high dependency ratios were significantly more likely to report out-of-school children.

School closures possibly also contributed to an exacerbation of protection risks for children, reportedly posing concerns not only related to education but also to children's well-being. **Child protection issues were reported to have**

⁸ Ibid.

increased since the lockdown, in particular child labour, which was reported to have increased in communities by almost half the households (49%).

Lastly, **almost half the households (48%) reported never having been consulted** on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak, and 45% reported **not having received clear awareness messages** on both cyclone early warning and/or sources of information.

Increased levels of need, coupled with reduced levels of income led to an **increasing adoption of livelihoods-based coping strategies, including crisis-level coping mechanisms**. As households were less able to rely on previously common coping strategies, such as borrowing money, they increasingly eroded assets and savings and adopted more crisis-level mechanisms. Such an erosion of coping capacities will likely render households more vulnerable to future shocks, such as a second disruption to assistance or a further loss of livelihood opportunities. It can further be expected to have **negative repercussions on health, food security and nutrition as well as household exposure to extreme protection risks**.

Households that were more vulnerable pre-COVID-19 are likely to also have been most vulnerable to the secondary impacts of the COVID-19 outbreak, including female-headed households or households without a working-age or adult male, households with persons with disability (PWDs), and large households or households with high dependency ratios. Households without adult males were significantly more likely to report having adopted a number of food-based coping strategies and to have relied on food rations or support from family or friends as the only sources of food and income due to a lack of money to meet basic needs. Households with PWDs were also significantly more likely to report having adopted emergency coping strategies as well as food-based coping strategies, as well as having relied on assistance or community support to obtain food, and/or having gone into debt to cover health expenses. Lastly, large households were significantly more likely as well to report having adopted emergency coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection.

Host communities largely lacked information on the types of humanitarian assistance available to them, with the majority of households reporting not having received enough information on any type of humanitarian assistance since the COVID-19 outbreak, with the exception of food assistance. **Household levels of satisfaction with assistance before and after the COVID-19 outbreak were similarly low**. However, households with female respondents more frequently reported that households had not received different types of assistance at all, while households with male respondents more frequently reported not having been satisfied.

Given the exacerbated needs and the severe erosion of coping capacities, as well as the quickly changing levels of need that can be expected as the pandemic evolves and humanitarian programming continues to be adapted, in the near and medium term, it will be of great importance to continue to **closely monitor needs and service gaps** to allow for continued evidence-based programming. Moreover, **additional information on the impact of the lockdown on levels of security, protection-related incidents and their impacts on household and individual well-being** is required to be able to effectively counter negative trends. Furthermore, a **better understanding of the impacts of the COVID-19 outbreak and associated containment measures on the most vulnerable households** may help more effectively alleviate those. Both will require carefully designed in-person data collection. In the long term and in the context of future MSNAs, a **more comprehensive assessment of key barriers to accessing different types of services faced by different groups of households and individuals** may contribute to reducing persisting vulnerabilities in the long run.

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List of Acronyms

AAP	Accountability to Affected Populations
BDT	Bangladeshi Taka
COVID-19	Coronavirus Disease 2019
CP	Child protection
CwC	Communication with Communities
DAP	Data analysis plan
DC	Deputy Commissioner
ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
FCS	Food Consumption Score
IGA	Income-generating activities
IMAWG	Information Management and Assessment Working Group
ISCG	Inter Sector Coordination Group
IOM NPM	International Organization for Migration Needs and Population Monitoring
J-MSNA	Joint Multi-Sector Needs Assessment
JRP	Joint Response Plan
KI	Key informant
KII	Key informant interview
LPG	Liquefied petroleum gas
NFI	Non-Food Item
NGO	Non-Governmental Organisation
PLW	Pregnant/lactating women
PPS	Probability-proportional-to-size
PSEA	Protection against sexual exploitation and abuse
PWD	Person with disability
RRRC	Refugee Relief and Repatriation Commissioner
SDR	Secondary data report
SEG	Strategic Executive Group
SGBV	Sexual and gender-based violence
SOP	Standard Operating Procedure
TWG	Technical Working Group
UNHCR	United Nations High Commissioner for Refugees
UNO	Upazila Nirbahi Officer
WASH	Water, Sanitation and Hygiene
WFS	Women-friendly spaces
WFP	World Food Programme

Geographical Classifications

District	Third tier of administration in Bangladesh, forming sub-units of divisions
Upazila	Fourth tier of administration in Bangladesh, forming sub-units of districts
Union	Fifth tier of administration in Bangladesh, forming sub-units of upazilas
Ward	Sixth tier of administration in Bangladesh, forming sub-units of unions

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INTRODUCTION

The District of Cox's Bazar, located in southern Bangladesh, has some of the poorest living conditions in the country. It is characterised by low access to basic infrastructure and services compared to the national average.⁹ At the same time, over the past four decades, in successive waves, the district has received Rohingya refugees fleeing violence in Rakhine State, Myanmar. Since August 2017, an estimated 745,000 Rohingya refugees have fled to Cox's Bazar District, where approximately 860,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas.¹⁰

Ukhiya Upazila is characterised by above-average levels of poverty and poor living conditions compared to the rest of the country. It is ranked the poorest upazila in Cox's Bazar District and among the 50 most socially deprived in the country. Despite all of Ukhiya being under the rural electrification network, the majority of the population does not have access to electricity. The upazila has the highest open defecation rate in the district, high rates of child labour, and low levels of food security. Evidence suggests that the refugee influx further exacerbated levels of poverty in Ukhiya.¹¹

Teknaf is also among the poorest upazilas in Cox's Bazar and ranking among the 50 most socially deprived in the country. Levels of food insecurity are high, as is the population's level of vulnerability to market price fluctuations. The upazila is also characterised by low levels of access to electricity, and limited access to drinking water, sanitation and health facilities. It has the lowest literacy rate in Cox's Bazar District and a high prevalence of child labour. Both may have been compounded by the refugee influx – on the one hand, by host community teachers having left schools to work for higher wages in camps, and on the other hand, by boys increasingly having dropped out of school to make use of increased working opportunities in and around camps.¹²

Needs in Ukhiya and Teknaf arise mainly from existing development challenges, but may have been compounded by the refugee influx.¹³ **With the refugee population being almost double the host community population in the two upazilas,**¹⁴ the massive increase in population density following the influx, coupled with the pre-existing lack of livelihoods, levels of poverty and vulnerability among the host community population, has led to tensions over labour competition, falling wages and price hikes of daily essentials. Perceived increases in crime, security concerns, and high pressures on the environment leading to deforestation and depleting water sources have further been reported as sources of tension.¹⁵

With the refugees unlikely to return to Myanmar in the near or medium term¹⁶, and the response having moved beyond the initial emergency phase, comprehensive information on the needs and vulnerabilities of all affected populations is needed in order to inform the design and implementation of effective inter-sectoral programming. Moreover, the challenges presented by the monsoon and cyclone seasons require regularly updated analyses of household needs and access to services. At the same time, the outbreak of the COVID-19 pandemic in early 2020 and associated

⁹ ACAPS, *Cox's Bazar: Upazila Profiles (September 2020)* (Cox's Bazar, 2020). Available [here](#) (accessed 23 November 2020).

¹⁰ Inter Sector Coordination Group (ISCG), *Situation Report Rohingya Refugee Crisis, Cox's Bazar, Bangladesh, June 2020* (Cox's Bazar, 2020a). Available [here](#) (accessed 23 November 2020).

¹¹ ACAPS, 2020

¹² *Ibid.*

¹³ Inter Sector Coordination Group, *2020 Joint Response Plan, Rohingya Humanitarian Crisis, January – December 2020, Bangladesh* (Cox's Bazar, 2019). Available [here](#) (accessed 23 November 2020).

¹⁴ Bangladesh Bureau of Statistics, *Population & Housing Census-2011, National Volume-2: Union Statistics* (Dhaka, 2011).

¹⁵ ACAPS, 2020; ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA): Host Communities – In-Depth | August – September 2019* (Cox's Bazar, 2019). Available [here](#) (accessed 23 November 2020).

¹⁶ International Crisis Group (ICG), *A Sustainable Policy for Rohingya Refugees in Bangladesh*, Asia Report N°303, 27 December 2019 (Brussels, 2019). Available [here](#) (accessed 13 November 2020).

containment measures put thousands of people in Cox's Bazar at risk of losing their livelihoods and income.¹⁷ On 22 March 2020, all non-essential businesses and offices were closed nationwide, and people called upon to stay at home, except when needed to meet essential needs.¹⁸ Cox's Bazar was among the first districts opting for an official lockdown starting on 8 April 2020. As a result, a majority of households experienced substantial disruptions to their livelihoods and decreases in levels of income.¹⁹ Given the likely magnitude of the impact of the restrictions on livelihoods, as well as access to basic goods and services, an understanding of household-level multi-sectoral needs, capacities and access to services within the context of the COVID-19 containment measures will therefore be essential for a full understanding of priority needs for 2021.

Against this background, a Joint Multi-Sector Needs Assessment (J-MSNA) was conducted across host community populations to support detailed humanitarian planning and enhance the ability of operational partners to meet the strategic aims of donors and coordinating bodies. The general objective of the J-MSNA was to inform evidence-based strategic planning of humanitarian response activities by the Strategic Executive Group (SEG), the Inter Sector Coordination Group (ISCG) Secretariat, sectors, and sector partners, through the provision of up-to-date, relevant and comparable information on the multi-sectoral needs of host community populations in Cox's Bazar District.

The 2020 J-MSNA built on previous MSNAs, most notably the [2019 J-MSNA](#), with the aim to facilitate an understanding of the evolution of needs and service gaps across time, where possible. It was implemented through the ISCG's MSNA Technical Working Group (TWG) of the Information Management and Assessment Working Group (IMAWG), which is led by the ISCG and comprised of the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration Needs and Population Monitoring (IOM NPM), ACAPS, and REACH. Sectors were actively involved in research design, preparations for data collection, and the discussion of results and analyses.

In the following chapter, the specific objectives of the assessment and the research questions will be introduced. The scope of the assessment and the methodology will be outlined, including the sampling strategy, data collection parameters, data analysis and secondary data review. Moreover, ethical considerations, and challenges and limitations will be highlighted. Thereafter, findings will be presented, with a focus on needs and service gaps within the context of the COVID-19 containment measures. The findings section will conclude with a summary of results related to Accountability to Affected Populations (AAP). The report will then close with a concluding summary and outlook.

¹⁷ Food and Agriculture Organization of the United Nations, *Bangladesh – Cox's Bazar, Revised humanitarian response, Coronavirus disease 2019 (COVID-19), May-December 2020* (Cox's Bazar, 2020). Available [here](#) (accessed 23 November 2020).

¹⁸ ISCG, *2020 COVID-19 Response Plan, Addendum to the Joint Response Plan 2020, Rohingya Humanitarian Crisis, April – December 2020* (Cox's Bazar, 2020b). Available [here](#) (accessed 23 November 2020).

¹⁹ World Food Programme, *Cox's Bazar Urban Vulnerability Assessment* (Cox's Bazar, 2020a). Available [here](#) (accessed 23 November 2020).

METHODOLOGY

Specific objectives and research questions

Aiming to expand the body of analysis and address key information gaps by providing an accurate snapshot of the situation, the 2020 J-MSNA was conducted with the specific objectives to:

1. Provide a comprehensive evidence base of the diverse multi-sectoral needs among host communities to inform the 2021 Joint Response Plan (JRP);²⁰
2. Provide an analysis of how host community needs have changed in 2020 with an emphasis on the impact of the COVID-19 pandemic on multi-sectoral needs;
3. Provide the basis for a joint multi-stakeholder analysis process.

To this end, the J-MSNA sought to answer the following research questions:

1. What are the needs and service gaps within host communities?
2. What are the characteristics of households most in need?
3. What are the immediate and structural factors associated with these needs?
4. To what extent have these needs and service gaps been impacted by the COVID-19 pandemic?
5. What behaviours and coping strategies are households undertaking in order to meet their needs, in particular in view of the COVID-19 crisis, and what factors influence these behaviours?
6. What are households' perspectives on aid delivery, as well as their preferences, and priorities with regards to aid delivery for 2021?

Scope and tool development

In line with the geographical coverage and population targeted by both the previous and the 2021 JRP, the assessment targeted all Bangladeshi households living in Ukhiya and Teknaf Upazilas. Sectors covered included Food Security, WASH, Shelter and Non-food items (NFIs), Protection, including the Child Protection and Gender-Based Violence Sub-Sectors, Health, Education, Nutrition and Communication with Communities (CwC). All sectors as well as the Gender Hub were consulted during tool design. Both quantitative and qualitative data was collected.

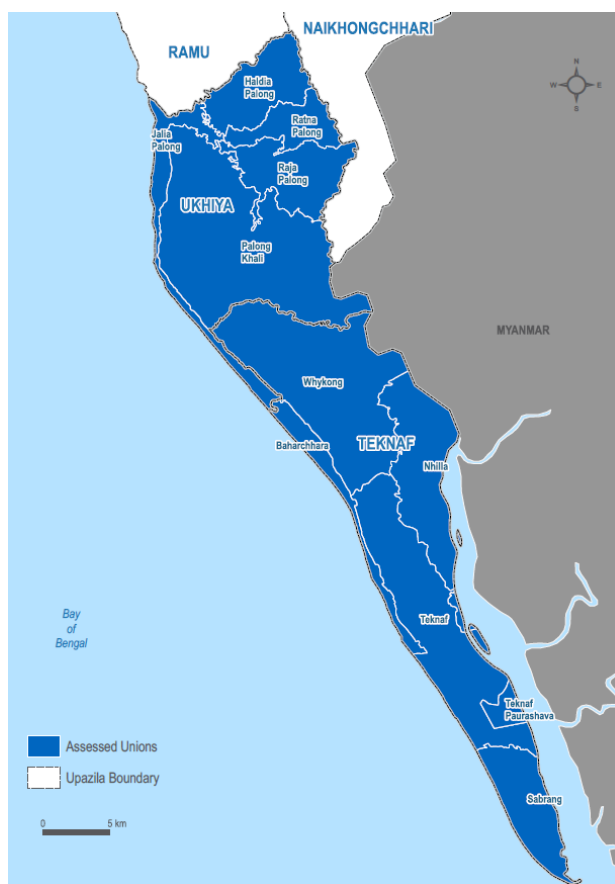
Quantitative component

For the quantitative household survey, the 2019 J-MSNA tool and indicators were reviewed and adaptations to the current context discussed during a first round of consultations with sectors. The MSNA TWG then developed a preliminary version of the 2020 J-MSNA questionnaire. As interviews had to be conducted remotely over the phone, however, questionnaire length had to be limited. Therefore, in a second step, sectors prioritised the indicators included in the preliminary version of the tool, which was subsequently finalised by the MSNA TWG giving priority to questions as indicated by sectors. The tool was translated to Bangla prior to enumerator training and data collection.

²⁰ A separate J-MSNA with the same objectives was simultaneously conducted in the refugee community.

Qualitative component

For the semi-structured key informant interviews (KIIs), the MSNA TWG, guided by the research questions least addressed by the quantitative tool, proposed topics and questions for inclusion to sectors. Sectors then revised and also prioritised the questions. The KII tool was subsequently finalised by the MSNA TWG based on sector feedback. It was translated to Bangla prior to enumerator training and data collection. The tool was structured into a section on CwC and AAP, and seven sectoral sections. Due to time constraints, each key informant (KI) was to be interviewed on CwC and AAP as well as two sectors of his/her choice, reflecting the sectors for which the KI thought assistance was generally hardest to access, had become significantly harder to access since the lockdown and/or represented the most urgent needs/biggest service gaps since the lockdown.



Map 1 Assessed unions in Ukhiya and Teknaf Upazilas, Cox's Bazar

Sampling strategy

Quantitative component

Households, defined as a group of people living together, and generally eating from one pot (sharing food), were the unit of measurement for this assessment. Due to the absence of a comprehensive sampling frame, the sampling frame was constructed from partners' household survey and beneficiary databases. A stratified probability-proportional-to-size (PPS) random sampling approach was used, with stratification at the upazila level and the aim of generating results

representative at the upazila level at a 95% confidence level and with a 5% margin of error. The primary source of population data was UNHCR survey data covering host community populations living within 6 km of UNHCR camps. The proportion of the sample for each union drawn from this database was equal to the proportion of households from the union included in the database. The remaining share of the sample was drawn from IOM and UNHCR beneficiary databases, covering wards within the targeted unions not included in the UNHCR database. In cases, in which a ward not included in the UNHCR survey data was included both in the IOM and the UNHCR beneficiary databases, the sample was drawn only from the database with the larger number of beneficiaries for that ward, as it could not be ensured that households were not drawn twice when sampling the same ward from both databases. For each database, sample size at the ward level was proportional to the ward-level population included in the database for each union. Moreover, as phone ownership was known to be more prevalent among men, in order to ensure adequate representation of female respondents, female-headed households were sampled proportionately to their representation in the databases. The final sampling frame only included host community households living within the vicinity of UNHCR camps and/or being UNHCR/IOM project beneficiaries. Further, only households registered with phone numbers could be included. Lastly, households in areas with little or no phone connection could not be reached.

An estimated buffer was included into all sample size calculations to account for (1) non-eligible households, such as mixed refugee-host community households registered as refugee households; (2) non-response, including non-functional phone numbers, households without mobile reception, or switched off phones; (3) non-consenting households, including households not consenting to or not finishing the survey; (4) households without an appropriate respondent, including all households without a consenting individual aged 18 and above; and (5) data cleaning/errors, including completed surveys that would be removed during data cleaning and therefore not be part of the final sample.

The interviews were conducted with the person answering the phone, usually expected to be the head of household, provided that consent was given and that the respondent was aged 18 or above. The enumerator teams were composed of roughly equal numbers of male and female enumerators. While female enumerators could interview respondents of either gender, male enumerators were instructed to only interview male respondents, and agree on a time with female respondents for a female enumerator to call them back. Overall, 33% of respondents were female and 67% of respondents were male. Forty-nine percent (49%) of female respondents and 1% of male respondents reported having replied on behalf of a female-headed household, with the remaining respondents having replied on behalf of a male-headed household.

Qualitative component

For the KIIs, a total of four interviews per union was targeted. KIIs were purposively sampled and included male and female ward members (local government representatives).

Data collection

Quantitative component

Quantitative data collection took place between 28 July and 13 August 2020. A total of 911 households, composed of 5,046 individuals, were surveyed across all unions.²¹ This included 470 households from Teknaf, and 441 households

²¹ A full list of completed interviews by union is included in annex 1.

from Ukhiya. Results are therefore representative at the upazila level of all host community households included in the sampling frame, i.e. households living in the vicinity of UNHCR camps and/or being UNHCR/IOM project beneficiaries, registered with phone numbers and in areas with mobile reception, at a 95% confidence level and with a 5% margin of error. They can further serve as a proxy of the entire host community population in Teknaf and Ukhiya. Data collection was led by REACH and data collected by 3 teams of UNHCR enumerators, consisting of 9 to 11 enumerators each, as well as 2 teams of IOM NPM enumerators, consisting of 6 enumerators each (43 enumerators in total).

Prior to data collection, enumerators underwent a four-day online training to familiarise themselves with the tool and data collection protocols.²² Sector representatives facilitated training sessions on the questionnaire sections pertaining to their sectors to ensure that the intent and wording of each question was well understood. The tool and data collection protocols were piloted with a sample of host community households during a two-day remote piloting exercise to identify and rectify problems before the full roll-out of data collection. Following the piloting, the tool was further refined based on lessons learnt during the pilot related to phrasing/understanding of the questions by both the enumerators and the respondents, displaying/sequencing of questions on the screen or missing response options.

During the interviews, data was entered directly into tablets using the KoBoCollect software. At the end of each day, surveys were uploaded to the UNHCR server, where raw data was accessible only to one individual within REACH. Data was checked and cleaned on a daily basis according to a set of pre-established Standard Operating Procedures (SoPs) in line with defined minimum standards, including outlier checks, the correct categorisation of “other” responses, the identification and removal or replacement of incomplete, inaccurate or incoherent records, and the recoding and standardisation of entries. All changes to the data were documented in a data cleaning log. Based on observations during the pilot, 20 minutes was established as the minimum length of the interview required to ensure an acceptable level of data quality. Any interviews falling below this threshold were excluded from the final dataset. Moreover, each respondent in the sample was allocated an ID, based on which and together with information on location (union and ward number), it was attempted to verify that the correct households had been interviewed. In total, 32 of 943 completed interviews were deleted from the final dataset due to quality issues related to timing or duplicate respondent IDs that could not be corrected.

Qualitative component

Qualitative data collection took place between 20 and 30 August 2020. A total of 23 KIs were interviewed, including 13 male and 10 female KIs. For security reasons and due to a lack of permissions, no KIs were conducted in Haldia Palong, Raja Palong, Ratna Palong, Sabrang and Teknaf Pourashava.²³ The sectoral sections of the questionnaire were discussed by a minimum of three (Shelter/Non-food items (NFIs) and Food Security) and a maximum of eight (WASH), or an average of five KIs each. Given this limited number of interviews per sector, while serving as a basis for the contextualisation and validation of quantitative findings, results should be interpreted cognisant of the fact that data saturation was likely not reached.

Data collection was led by REACH and conducted with a team of eight REACH and IOM NPM enumerators. Prior to data collection, enumerators underwent a one-day online training to familiarise themselves with the tool, and data collection protocols. The training included practice sessions to test the phrasing and understanding of the questions.

²² The enumerator training agenda is included in annex 3

²³ A full list of completed KIs is included in annex 2.

Following the training and prior to the start of data collection, the tool was finalised based on enumerator feedback during the training.

The interviews were in part conducted remotely over the phone and in part in-person. The phone interviews were recorded and the recordings used as a basis for transcription and analysis. During the in-person interviews, enumerators took notes that supported transcription and analysis.

Data analysis

Results were analysed by sector. The requirement to limit questionnaire length also imposed constraints on the types of analysis that could meaningfully be conducted. As such, no comprehensive quantitative inter-sectoral analysis was carried out. The estimation of the proportion of households in need and corresponding caseloads was also beyond the scope of this assessment. However, qualitative results and the secondary data review provided a foundation, based on which qualitative links between sectoral outcomes could be drawn and a more holistic picture of needs and service gaps be provided. Lastly, while current levels of need have to be explained within the context of the COVID-19 outbreak and associated containment measures, it was beyond the scope of this assessment to analyse expected levels of need if the containment measures had not been put into place. The findings are therefore intended as an overview of existing levels of need and not as an evaluation of the lockdown or COVID-19 containment measures.

Quantitative component

A basic data analysis plan (DAP) was drafted, outlining stratifications, additional composite indicators to be constructed and the basic descriptive statistics to be calculated for each indicator. The DAP was reviewed by sectors and finalised by the MSNA TWG based on sector inputs. To account for the unequal distribution of households across the two upazilas, results were weighted at the upazila level during the basic descriptive analysis.

Secondly, based on sector characterisations of vulnerable households, the MSNA TWG identified a range of indicators, for which the existence of statistically significant differences in outcomes between households of different socio-economic characteristics was tested. Pearson's chi-square test of independence was used to determine whether or not there was an association between the household characteristics and indicator outcomes. Relationships were determined to be statistically significant for $p\text{-values} \leq 0.05$. For tests involving more than two distinct groups of households across a certain characteristic, if a significant difference was generally found to exist between the groups, a post-hoc analysis based on the residuals of the chi-square test was conducted to determine the group(s) driving the significant difference. Data was further analysed by upazila, and by gender of respondent for indicators for which differences in perceptions between male and female respondents were expected. Moreover, basic statistics were calculated disaggregated by the gender of the head of household as well as by the presence or absence of adult males in the household. The latter was expected to serve as a proxy of female-headed households with a female person also being the main decision-maker in the household. For selected indicators, the existence of statistically significant differences between upazilas, households with male and female respondents, as well as households with and without adult males was tested.

Lastly, in cases in which indicators were comparable, 2020 J-MSNA results were compared to 2019 J-MSNA results. No statistical significance testing was conducted for 2019 to 2020 comparisons because of very different sample sizes.

However, large differences (typically differences of more than ten percentage points) were considered in the interpretation of the results and are presented in the following, where relevant.

Preliminary findings, including basic descriptive statistics, selected significance tests, and 2019 to 2020 comparisons, were shared with sectors. During individual sector meetings, results were further discussed, validated and opportunities for additional analyses identified.

Qualitative component

A basic DAP was drafted, outlining how the qualitative component would feed into answering the overall research questions. The DAP was reviewed by sectors and finalised by the MSNA TWG based on sector inputs. KII recordings/notes were translated and transcribed at the end of the data collection process. With the DAP used as a starting point to identify key themes, the translated transcripts were then processed in NVivo to draw out trends, themes, and key messages across interviews.

Secondary data review

To support the contextualisation of the findings from the primary data collection exercise and in light of the drastic change in the situation brought about by COVID-19 and the associated containment measures, the ACAPS – NPM analysis hub produced seven brief response-level secondary data reports (SDRs) for specific sectors and working groups engaged in the MSNA process.

Each SDR focused on how the affected populations' lives had changed since the last J-MSNA in 2019 had been conducted and aimed at highlighting potential unmet needs and the specific challenges people were now facing when meeting their basic needs. These reports were developed in collaboration with the various coordination bodies and consist of publicly available secondary information as well as internal specific operational reports. The SDRs used statistically representative assessments conducted pre-COVID-19 as a baseline, and small-scale assessments and analyses, both quantitative and qualitative, that were conducted during the COVID-19 response to assess changes, gaps and challenges.

Each sector was given the opportunity to review their specific report to ensure accuracy and appropriateness before the reports were combined and shared with the MSNA TWG for analysis alongside the 2020 J-MSNA findings. Where relevant, the reviewed secondary data is integrated and referenced throughout this report.

Ethical considerations and dissemination

During the research design, a data protection risk assessment was conducted to ensure that all necessary measures were taken to prevent harm to respondents from accidentally exposing their identities. In advance of the survey, respondents were informed of their right not to participate, not to answer specific questions or to end the interview when they wished. Informed consent was sought, received and documented at the start of each interview. Moreover, the enumerator training included dedicated training sessions on research ethics and code of conduct, including AAP, Protection from Sexual Exploitation and Abuse (PSEA), and good interviewing practices. The Protection Sector was

consulted during research design and during the training, in order to safeguard against exposing respondents, and in particular women, to risks as a result of the remote nature of the survey, during which privacy could not be ensured.

Following the preliminary presentation of results to sector partners, a [factsheet](#) highlighting key results was produced and disseminated to all sectors, the Cox's Bazar Deputy Commissioner (DC), and the Refugee Relief and Repatriation Commissioner (RRRC). Furthermore, key findings were shared with the DC, the Teknaf and Ukhiya Upazila Nirbahi Officers (UNOs), and the RRRC.

Challenges and limitations

Challenges and limitations of the assessment include:

- **Remote data collection:** Due to restrictions on movement and face-to-face interviews as part of the COVID-19 containment measures, all interviews were conducted over the phone. This created some challenges and limitations:
 - Given the expected poor connectivity and the lack of personal interaction during a phone interview, both quantitative and qualitative data collection tools were limited in length to avoid losing respondents' attention. Questions were prioritised and household questionnaire length was limited. Moreover, KIs always only discussed selected sections of the KII questionnaire.
 - As privacy could not be ensured during phone interviews, in order to avoid creating risks to respondents, sensitive topics were not included in the quantitative component of the assessment but rather attempted to be captured by the qualitative component and through the secondary data review.
 - As phone ownership is more prevalent among men, a lower proportion of households with female respondents were reached than might have been reached during an in-person survey. However, the sampling approach still allowed to include 33% of female respondents, with 49% of them reportedly having replied on behalf of a female-headed household.
 - Unequal phone ownership may have slightly biased results towards better educated households.
- **Sampling frame:** As the sampling frame did not cover the entire host community population, results can only be considered representative of the population included in the sampling frame. They can serve as a proxy, however, of the entire host community population of Teknaf and Ukhiya.
- **Data analysis:** The limits on questionnaire length and resulting constraints on the quantity of information captured as well as the remote nature of the survey constraining the types of information possible to collect also limited the possible types and depth of analysis. As such, no comprehensive quantitative inter-sectoral analysis was conducted. The estimation of the proportion of households in need and corresponding caseloads was also beyond the scope of this assessment. However, qualitative results and secondary data were used to draw qualitative links between sectoral outcomes and obtain a more holistic picture of needs and service gaps.
- **Proxy reporting:** Data on individuals was collected by proxy from the respondent, not directly from household members themselves. Results might therefore not accurately reflect lived experiences of individual household members.
- **Subset indicators:** Findings related to a subset of the overall population, e.g. only to households with school-aged children, may have a wider margin of error, yielding results with lower precision. Any findings representative only with lower levels of precision are indicated as such throughout the report.

- **Respondent bias:** Certain indicators, such as perceived security threats, may be under- or over-reported due to the subjectivity and perceptions of respondents. For instance, respondents might have the tendency to provide what they perceive to be the “right” answer to certain questions (“social desirability bias”).
- **Perceptions:** Questions on household perceptions may not directly reflect the realities of service provision by humanitarian actors but only respondents’ perceptions of them.
- **Limitations of household surveys:**
 - While household-level quantitative surveys seek to provide quantifiable information that can be generalised to the population of interest, the methodology is not suited to provide in-depth explanations of complex issues. Thus, questions on “how” or “why” are best suited to be explored through the accompanying qualitative component as well as triangulation with secondary data.
 - Since “households” are the unit of analysis, intra-household dynamics, for instance related to gender norms, roles, disability or age, cannot be captured. Users are reminded to supplement and triangulate household-level findings with other data sources.
- **Timing of assessment:** When interpreting the findings, users are informed that data collection was: (1) conducted following months of limited access to livelihoods due to COVID-19-related restrictions; (2) implemented during the monsoon season; and (3) included the festival of *Eid-al-Adha*.

FINDINGS

Priority needs

The most commonly reported priority needs included access to food, access to cash, and shelter materials. Other priority needs included access to income-generating activities (IGAs) and access to clean drinking water (Figure 1). Compared to 2019,²⁴ especially the proportion of households considering access to food and access to IGAs priority needs (42% and 22% in 2019 – access to cash was not assessed in 2019) increased considerably, likely reflecting the impact of the COVID-19 outbreak and associated containment measures on food security and livelihoods.

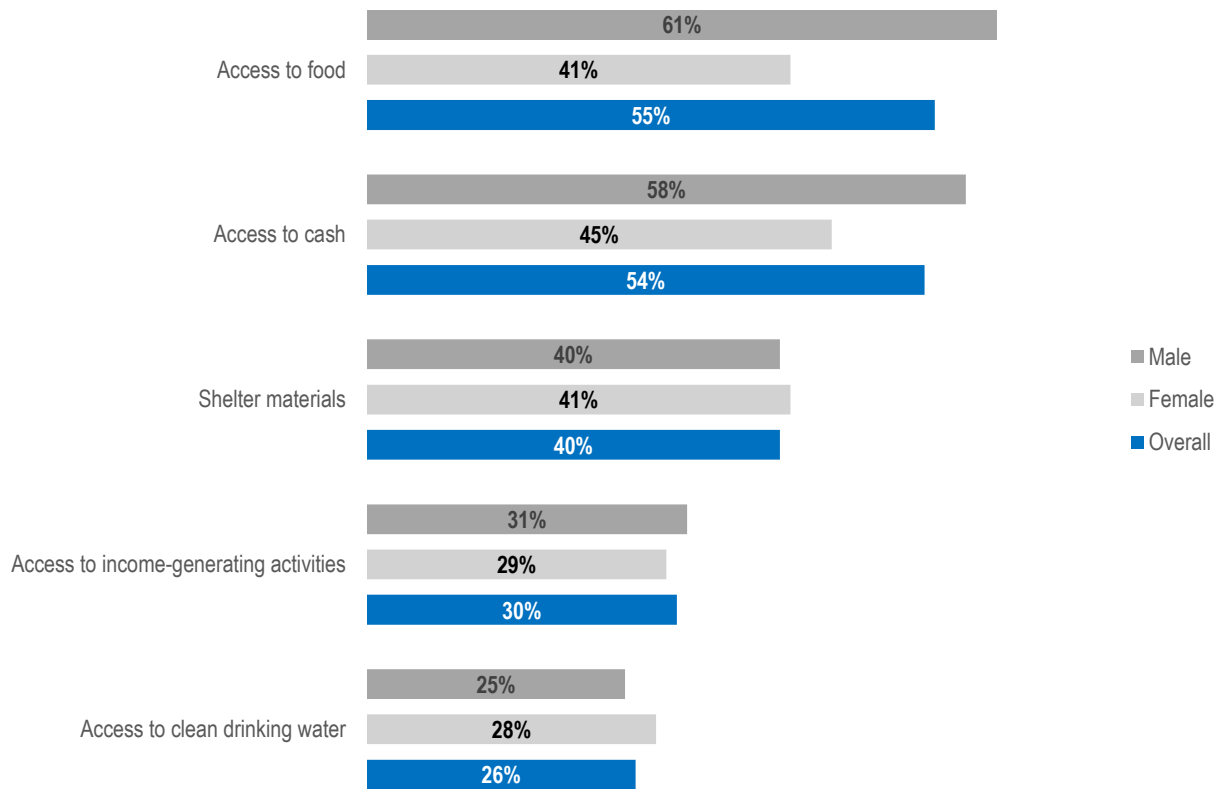


Figure 1 % of households reporting priority needs, overall and by gender of respondent (top 5)²⁵

A slightly higher proportion of households reported preferring receiving fuel assistance in-kind than reported preferring cash or a combination of both, while for food and shelter materials, the majority of households reported preferring in-kind assistance (Figure 2). The preferred modality for food assistance differed, however, between households with male and female respondents. Only 41% of households with female respondents²⁶ reported preferring cash, compared to 58% of households with male respondents. On the other hand, 35% of households with female respondents reported preferring a combination of cash and in-kind assistance compared to 22% of households with male respondents.

²⁴ ISCG, 2019.

²⁵ Results for households with female respondents are representative with a +/-6% margin of error (n = 295). Respondents were asked to identify the top three priority needs.

²⁶ Results for households with female respondents are representative with a +/-9% margin of error (n = 119).

Related to shelter support, in addition to the modalities presented in Figure 2, 13% of households reported preferring labour support.²⁷

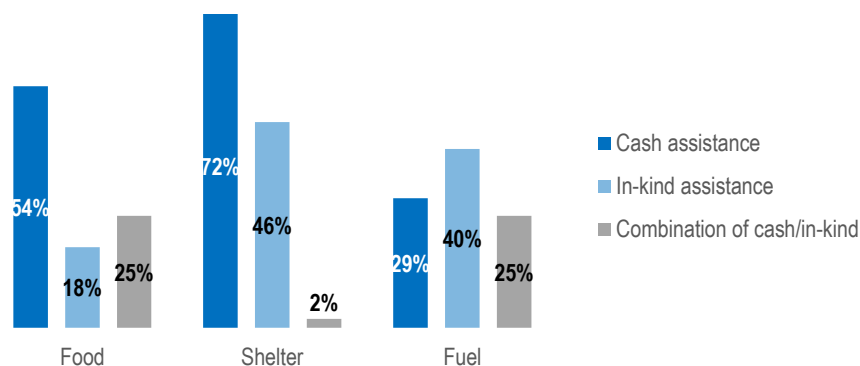


Figure 2 % of households reporting preferred modality to receive assistance²⁸

Needs and service gaps

Persistent needs and service gaps

Certain needs and service gaps that had already existed pre-COVID-19 remained unchanged, in particular those related to shelter/NFIs, access to drinking water, nutrition-feeding programmes, education and communication with humanitarian actors. The majority of households (59%) reported having faced issues with their shelter in the six months prior to data collection, and one quarter (24%) reported not having made any improvements despite having faced issues. Most commonly households reported not having been able to make improvements due to a lack of money to pay for materials (reported by 39% of households not having made improvements) and/or labour (9%). Shelter support from humanitarian actors reportedly was almost non-existent in the host communities, with only 1% of households having made improvements to their shelters reporting having received materials from humanitarian organisations. In contrast, 90% of households reported having purchased materials, and 16% reported having reused existing materials to make improvements to their shelters.

Similarly, 35% of households reported having bought liquefied petroleum gas (LPG) as a source of cooking fuel in the four weeks prior to data collection, and only 17% reported having received it from humanitarian agencies. Overall, only roughly one quarter of households (26%) reported having relied exclusively on LPG as a source of cooking fuel in the four weeks prior to data collection, and over 40% of households reported having used purchased and/or self-collected firewood (Figure 3). Compared to last year, the proportion of households reportedly having relied exclusively on LPG increased considerably from 15% to 26%, while the proportion of households reporting having bought firewood decreased considerably from 63% last year.²⁹ However, whether or not this indicates a positive trend towards more households being able to rely on LPG or rather access issues related to different sources of fuel as a result of COVID-19 containment measures remains to be seen.

²⁷ Results for households with female respondents are representative with a +/-6% margin of error (n = 362).

²⁸ Respondents were asked their preferred modality to receive these items if they reported any of them as a priority need. Results for the preferred modality to receive shelter assistance are representative with a +/-6% margin of error (n = 362). Results for the preferred modality to receive fuel assistance are representative with a +/-9% margin of error (n = 141).

²⁹ ISCG, 2019.

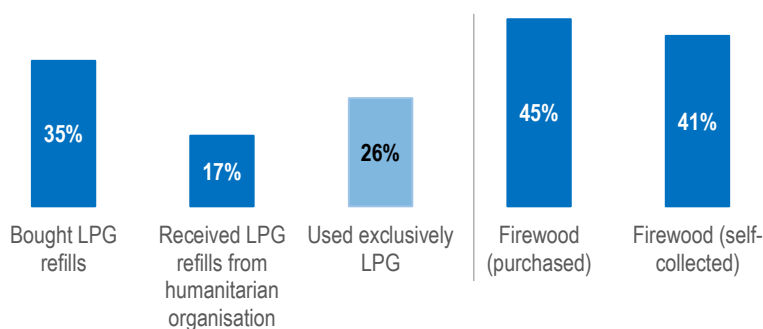


Figure 3 % of households reporting source of cooking fuel in the 4 weeks prior to data collection

Shelter issues, in particular during the monsoon season, as well as the high reliance on sources of cooking fuel other than LPG are both pre-existing gaps unrelated to the lockdown. At the same time, a high reliance on markets for both shelter materials and fuel sources (as well as other NFIs) is generally underpinned by access to livelihood opportunities and income. Nevertheless, COVID-19 containment measures and the resulting loss of income may have made it harder for households to meet their needs by themselves.

“People do not buy new materials because when the lockdown started, their income was reduced.”
Female KI (Teknaf)

“They are facing problems, but somehow they try to buy gas, even taking loans. As firewood is not available, they need to buy gas. Gas is an essential item for them, without it they have to starve, so that’s why they borrow money to buy it and later repay it.” – Male KI (Teknaf)

The majority of households reportedly continued using tubewells as one of their main sources of drinking water (88%), but almost one quarter (23%) reported not having enough water to meet domestic needs, including for drinking, cooking, personal hygiene and other domestic needs, despite data collection having been conducted during the rainy season. Several KIs reported insufficient depth of tubewells and a lack of water becoming a problem in particular during the dry season. Poor water quality was further mentioned by several KIs. One KI perceived the lack of water to be in part due to environmental degradation caused by the refugee influx.

“Yes they are facing lots of difficulties. We have very few tubewells here. During the dry season, the water crisis gets severe in the area. [...] Though in the rainy season, water is available, it is not pure enough.” – Female KI (Teknaf)

“One NGO is setting up seven tubewells in my area. But there are few areas, where they are facing a water crisis, as there are stones in the water. The depth is not sufficient to pump enough water from underneath the soil. It would be good if any NGO would help these areas, but it’s quite expensive. No NGO tries to help, as they are not aware of the problem in those areas.” – Male KI (Teknaf)

“Already before [COVID-19] people faced a water crisis in this area. [...] The problems are poverty, environmental degradation after the Rohingya came here, increasing prices for hygiene items, water has dried up underneath the soil, and a lack of awareness.” – Male KI (Ukhiya)

Sanitation and waste management also remain problems, with 14% of households reporting adult household members sometimes practising open defecation and 11% of households reporting often or sometimes finding visible waste in the vicinity of their accommodation. A lack of money makes it difficult for people to repair dysfunctional WASH facilities, resulting in the adoption of negative coping mechanisms.

“They are day labourers. They earn BDT 200³⁰ daily and try to manage their essential needs with this money. [...] People use those broken latrines, sometimes they defecate in open spaces. And for broken tubewells, if the government supports, they are repaired, otherwise they remain the same.” – Male KI (Teknaf)

The proportion of households with pregnant and/or lactating women (PLWs) reporting PLWs to be enrolled in nutrition-feeding programmes remained low (12%), as did the proportion of children aged 6 to 59 months reportedly enrolled in nutrition-feeding programmes (15%). A lower rate of enrolment in nutrition-feeding programmes compared to the refugee communities is expected due to differences in programming and enrolment criteria. In addition, high staff turnover in nutrition centres following the large refugee influx in 2017 may also slightly have reduced access, as nutrition staff went to work in camps.³¹ Overall, 40% of households with children aged 6 to 59 months and/or PLWs reported not facing any barriers enrolling children and/or PLWs into nutrition-feeding programmes. Sixteen percent (16%) of households reported that they did not know what the barriers were. Another 10% reported that nutrition centres were too far, 7% reported children/PLWs to have been rejected from nutrition centres, and 6% each reported that households had not gone to nutrition centres out of fear of contracting COVID-19 on the way and/or that children had not been screened and were therefore not enrolled. The fact that 16% of households were not able to name the barriers they were facing enrolling children/PLWs into nutrition-feeding programmes indicates limited awareness or understanding of such programmes. Some of the households not able to name barriers also explicitly stated that they were not aware of any nutrition support in their areas. A possible lack of information on nutrition services, with 87% of households reporting not having received enough information on nutrition services since the COVID-19 outbreak (see Figure 36), may be a further reason for this lack of awareness. At the same time, KIs did also report limited nutrition programming in the assessed areas as well as services having been scaled down at the start of the lockdown.

“No, they are not receiving [nutrition] services. From my union parishad, we received shuji packets and milk jars during the lockdown, after that we didn’t receive anything. We received it once in the last 4 years, and got only 26 packets, though we have more than 15,000 people in my ward.” – Female KI (Teknaf)

“Before the lockdown, they didn’t receive [nutrition] support, even now they are not receiving it. [...] The service is not available in this ward. [...] The main problems are a lack of government support, and also if the government takes such an initiative, ordinary people don’t care about this.” – Male KI (Ukhiya)

“[Nutrition] service was active a bit well before the lockdown, but after the lockdown, it got completely stopped. [...] Nutrition packets were not provided after the lockdown.” – Female KI (Ukhiya)

Furthermore, overall school enrolment rates remained low in the host community, with 40% of individuals aged 4 to 24 reportedly not having attended any type of formal education for at least four days a week in the 30 days prior to school

³⁰ 1 Bangladeshi Taka (BDT) = 0.0117962 US Dollars (USD) (XE Currency Converter, available [here](#), accessed 11 December 2020).

³¹ Action Contre la Faim, Coverage Assessment (SQUEAC) of CMAM Programme, Upazilas of Ukhiya and Teknaf, Cox’s Bazar District, Bangladesh, March 2019.

closures due to the COVID-19 outbreak, or 31% of households reporting at least one school-aged child (5-17 years old) not having attended any formal learning for at least four days a week prior to school closures due to the COVID-19 outbreak. Especially young adults were largely reported as not having attended any formal education – only 19% of females aged 18-24 and 36% of males of the same age group reportedly regularly attended formal learning in the 30 days prior to school closures due to the COVID-19 outbreak. Compared to the J-MSNA 2019 results, enrolment rates for 5 to 11 and 12 to 17 year olds seem to have increased. This has to be interpreted with caution, however, as this year’s survey may have slightly biased the result towards better educated households, which may have had a positive impact on reported school attendance, as households with primary education or less were significantly more likely to report out-of-school children, while those with secondary education and above were significantly less likely to report out-of-school children (in both cases, $p\text{-value} \leq 0.0001$) (Figure 4). Also households with a high dependency ratio were significantly more likely to report out-of-school children (Figure 5), indicating a higher likelihood of children from those types of households not to receive an education and to be vulnerable to potential secondary impacts, such as child labour.



Figure 4 % of households reporting out-of-school children by the highest level of education in the household³²

Figure 5 % of households reporting out-of-school children by dependency ratio ($p\text{-value} \leq 0.01$)³³

Two KIs from Teknaf further reported a lack of schools as well as poverty as reasons for children not accessing education. A lack of money may potentially have become even more of a driver for children to drop out of education after income-earning was disrupted by the COVID-19 outbreak and associated containment measures.

“In my area, there is just one primary school, where children from two to three villages can access education, and also only two small types of madrassahs. These are not enough for children in my area, as a result they are getting deprived of education. There is a village on the top of the hill, which is quite far from other areas. [...] There is not a single educational institution over there. Children in these areas work on the paddy land from their childhood. So, education is bad in this area, as there is no educational institution.” – Male KI (Teknaf)

³² Results for households with primary education or less are representative with a +/-6% margin of error (n = 306). Results for households with secondary education and above are representative with a +/-9% margin of error (n = 147). The error bars represent the 95% confidence interval for the mean value. This means that with 95% confidence the true value will be within this interval. For instance, the true value of households with primary education or less that have out-of-school children is between 43% +/- 6%, i.e. between 37% and 49%. If the survey was repeated 100 times, in 95 cases, the result would be expected to be between 37% and 49% and in 5 cases it would fall outside those bounds.

³³ Results for households with a high dependency ratio are representative with a +/-16% margin of error (n = 44).

“The number of poor people is high in my area. Poor parents can’t afford their children’s education. They are not able to buy study materials, like notebooks, pens, or school uniforms for them. That’s why many students drop out of school. Parents earn some money, which is even not enough to buy food. This was the condition before the lockdown, and after the lockdown everything got stopped.” – Female KI (Teknaf)

Lastly, there continue to be gaps in the host community’s interaction with humanitarian actors. Host community involvement in the design of humanitarian programmes remains limited, with almost half the households (48%) reporting never having been consulted on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak. Possibly linked to this, one KI reported the provided assistance not having been useful for many people. Others reported challenges for specific groups, such as elderly or less educated people, in receiving assistance.

“Services that are being provided by NGOs are not accessible to all people, few are receiving them, few are not. For many people, the support is not useful or effective, rather it would be good to support infrastructure development, like roads, bridges, etc.” – Male KI (Ukhiya)

“Elderly people and women face some difficulties, if they need to collect distributions. They need to wait in the queue, which is quite challenging for them. Some NGOs provide money via bank accounts and uneducated people don’t understand the process and they keep running to the shop or village police. [...] To support elderly men and women, we need to add their sons’ or daughters’ names as nominees on the card, so they don’t need to come to collect the distributions themselves” – Male KI (Teknaf)

Clear awareness messages, in particular related to cyclones, were also only partially received. Generally, messaging related to COVID-19 was more successful than messaging related to cyclones with a higher proportion of households reporting having received clear awareness information on COVID-19-related topics than topics related to cyclones (Figure 6). Potentially, lessons learnt from COVID-19 messaging could be applied to strengthen cyclone messaging in the future.

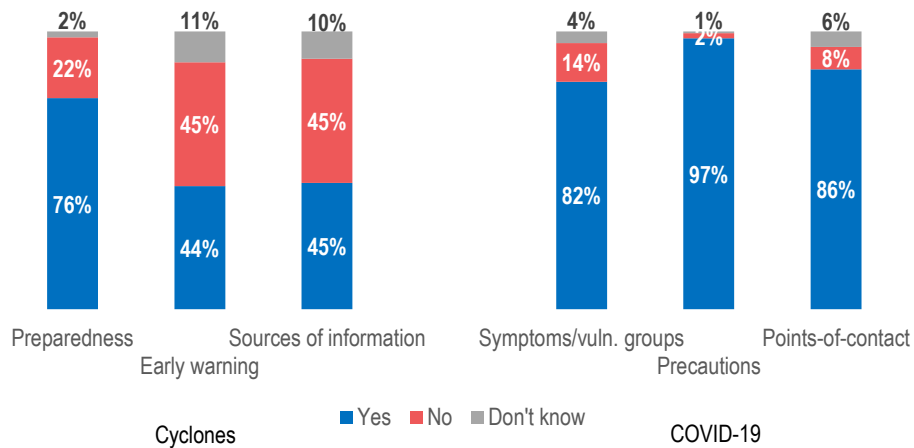


Figure 6 % of households reporting having received clear awareness information on different topics

Exacerbated needs and service gaps

Other needs and service gaps were exacerbated by the lockdown, in particular those related to food security and livelihoods, health-seeking behaviour, and (child) protection and well-being. Almost all households (93%) reported diminished/lost source of income as an impact of the COVID-19 outbreak, and 66% reported limited access to food. Roughly a quarter (27%) reported a loss of or diminished access to education (27%) and 17% reported a loss of or severely diminished access to basic services (Figure 7).

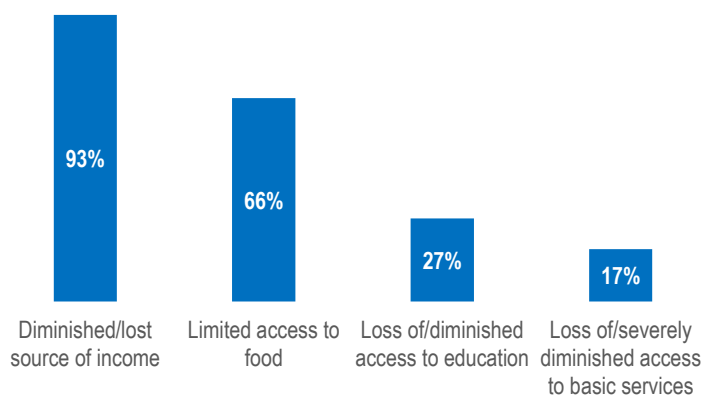


Figure 7 % of households reporting impact of the COVID-19 outbreak on the household

The biggest impact of the COVID-19 outbreak on households appeared to be the disruption it caused to income-earning. While the proportion of individuals aged 18 to 59 reported working to earn an income (38%) remained comparable to last year (41%),³⁴ livelihoods suffered a major impact leading to a drop in income levels as a result of the COVID-19 outbreak and associated containment measures. Between March and early May 2020, households in Ukhiya reported an average loss of income of BDT 8,400 per month.³⁵ This corresponds to more than half the average monthly income households had reportedly earned pre-COVID-19.³⁶ The partial re-opening of the economy in June 2020 resulted in marginal economic recovery, with a reduction in the levels of lost income. However, full economic recovery, especially of those most affected, is not expected in the short term.³⁷

The drop in income is likely to have severely hindered food access for households. Despite scaled-up livelihoods and food assistance by humanitarian actors,³⁸ Food Consumption Scores (FCS) in the host community had worsened by May 2020, with 8% of households having a poor FCS,³⁹ compared to 4% in 2019.⁴⁰ Similar levels of FCS continued into July, when at the time of data collection, still 8% of households were assessed to have a poor FCS, and only 43% of households had an acceptable FCS, compared to 72% in 2019⁴¹ (Figure 8).

³⁴ ISCG, 2019.

³⁵ WFP, COVID-19 Impact on Refugees and Host Communities - May 2020 (Cox's Bazar, 2020b). Available [here](#) (accessed 27 November 2020).

³⁶ WFP, Refugee influx Emergency Vulnerability Assessment (REVA) – Cox's Bazar, Bangladesh, May 2019 (Cox's Bazar, 2019). Available [here](#) (accessed 27 November 2020).

³⁷ WFP, 2020a.

³⁸ WFP, WFP COVID-19 response: support to the host community (Cox's Bazar, 2020c). Available [here](#) (accessed 27 November 2020).

³⁹ WFP, 2020b.

⁴⁰ ISCG, 2019.

⁴¹ Ibid.

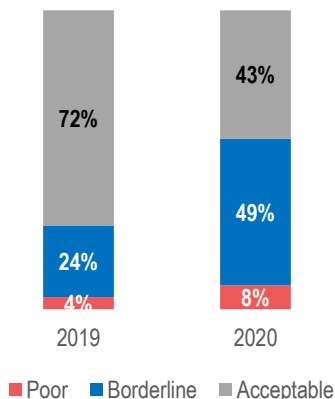


Figure 8 % of households by Food Consumption Score

Overall, three fourths of households (76%) reported having adopted food-based coping mechanisms in the seven days prior to data collection due to a lack of food, most commonly having relied on less preferred/expensive food (69%). Half the households (49%) reported having reduced portion size, 23% reported having borrowed food or relied on help, and 22% reported having reduced the number of meals a day, all of which likely reflects food shortages and consumption gaps.

In addition to the impact of the COVID-19 outbreak on livelihoods and food security, compared to 2019, a likely reduction in health-seeking behaviour was observed. The proportion of individuals reported sick enough to require medical treatment or to have required a regular medical check-up in the 30 days prior to data collection dropped from 31% in 2019⁴² to 14% in 2020 (Figure 9). However, drawing from discussions with the field team on respondents' understanding of the question and secondary data review, rather than a drop in the proportion of individuals that sought or should have sought treatment, this is likely to reflect a drop in the proportion of individuals that sought treatment when they should have. This is further supported by the fact that in both years almost all individuals (98% in 2019⁴³ and 97% in 2020) reported to have required treatment were also reported to have sought treatment, indicating a tendency to only report those individuals as having required treatment that did seek treatment.

At the same time, visits to private clinics of those seeking treatment dropped from 47% last year⁴⁴ to 36% this year (Figure 10), while the proportion of individuals who sought treatment reporting having sought it at pharmacies or drug shops in the market remained high (41%). Furthermore, the proportion of households reporting having adopted health-related coping strategies increased. Last year, 23% of households reported not having had to adopt any coping mechanisms to seek health treatment. This year, every household reported having adopted at least one coping strategy – ranging from home treatment for different reasons to paying for healthcare or going into debt to seek treatment.⁴⁵ As this indicates potentially increased challenges accessing or a decreased utilisation of health services, those changes in health-seeking behaviour are likely to have negative consequences for individual well-being.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.



Figure 9 % of individuals reported to have had an illness serious enough to require medical treatment or to require a regular medical check-up in the 30 days prior to data collection

Figure 10 % of individuals reported to have had an illness serious enough to require medical treatment or to require a medical check-up in the 30 days before data collection, for whom treatment was sought and who sought treatment at a private clinic

Levels of education and economic status have been found to be associated with health-seeking behaviour in Bangladeshi rural communities in other studies, as have other factors, such as household proximity to health centres.⁴⁶ Distance to health centres and high costs of treatment were also mentioned by KIs as barriers to seeking treatment, while 15% of households reported living more than one hour of walking distance from the nearest health facility (Figure 11), and only 8% reporting having received visits from a community health worker in the 14 days prior to data collection (Figure 12).

“We need to go far to get treatment. [...] My union is in one corner, but the health complex is in Teknaf Pourashava. So we are facing difficulties getting enough health facilities. We have few clinics, but these are also in one corner and far from our area. Not only in my ward, but in our union, we don’t have enough health facilities.” – Female KI (Teknaf)

“Mainly concerning is food, shelter and also treatment. They need to pay a huge amount of money to cover for treatment.” – Male KI (Teknaf)

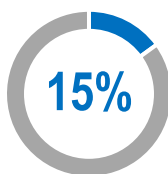


Figure 11 % of households reporting having to walk more than one hour to the nearest health facility

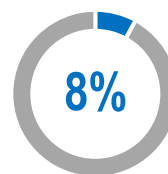


Figure 12 % of households reporting having received a visit from a community health worker in the 14 days prior to data collection

KIs reported those problems to have been exacerbated, as health centres were closed and the number of medical staff, in particular doctors, reduced at the start of the lockdown.

“People are not able to do regular treatment. Even my son got sick a few days ago and I took him to the hospital and I found no doctor there. So we are not getting treatment as needed. There is a lack of

⁴⁶ Khan, Md S.I. et al. (2018), "Healthcare-seeking behavior for infectious diseases in a community in Bangladesh." *International Journal of Advanced Medical and Health Research* 5, no. 2 (2018): 52.

doctors in the health centre due to the Corona outbreak. So few people died without getting treatment and few are suffering from other diseases. Though poor people used to get some treatment and medicine before the lockdown in the health centre, during the lockdown it was completely stopped. Now after the lockdown, it re-opened and gives some light treatment. In our union, we have three health centres. Patients from one village don't go to another village for treatment. They go to a traditional healer or normal doctor in the market and take medicine for normal fever, cough, etc.” – Female KI (Teknaf)

“Due to the lockdown two changes happened – health centres were closed and the number of doctors has reduced in the hospital.” – Female KI (Ukhiya)

“Health facilities are few. We need emergency doctors for Corona patients, but we are not getting them here. The regular government doctors are not even visiting patients here now. [...] But the health complex is active. People who live near the health centre can easily access the services, but it's difficult for other people who live quite far. [...] We have some general village doctors. People consult with them for medicine. If they need to go to Cox's Bazar, they go there for better consultations.” – Male KI (Teknaf)

“The problems are increased prices for medicine, that doctors are not available in the hospital as before, and that before government health assistants used to provide medicine to people's door, which has stopped now.” – Male KI (Teknaf)

Furthermore, schools closed in mid-March 2020 in compliance with COVID-19 containment measures.⁴⁷ Overall, 27% of households reported lost or diminished access to education as an impact of the COVID-19 outbreak, and KIs voiced concerns around the impact of school closures not only on children's education but also on their general well-being, frequently referring to disrupted daily routines, children being sent to work and girls getting married as major concerns.

“Due to school closures, children are falling behind in their studies [...] and the possibility of getting involved in bad activities is higher when they are not engaged in schoolwork. [...] As schools remain closed and many poor families are not able to run their families, they are marrying off their adolescent female children. [...] Only financially capable people are continuing their children's studies, but poor families are not doing anything for their children. [...] In my area one boy and one girl were sent for house maid work by their parents, where they get physically assaulted even for small mistakes. [...] Most of the families send their children to work due to financial problems, this has huge consequences for their studies.” – Male KI (Ukhiya)

“Obviously [the lockdown] has a great impact. Before a student had a daily routine. But now when a boy is not going to school, maybe he sits at a shop. Most of the time boys don't stay at home, so they go outside and pass their time gossiping, or playing with others. Their mentality has changed a lot. Before their mind setup was like this – they used to go to school at 9 in the morning and come back at 4 pm, and then played for two hours and again studied at night. But now the whole day time they are free, so what they do is gossip at shops. [...] For girls when they stay at home, they help their parents with household chores. But when girls are unemployed at home, some bad thinking comes up and it's normal in the society. And I also noticed that when boys and girls are not going to school, they are getting

⁴⁷ ISCG, 2020b.

involved in relationships between themselves, which has increased a lot compared to before.” – Male KI (Teknaf)

“Children are not studying in my ward. Those who can, they are working. Many students have become bad now. [...] Child marriage is happening a lot. [...] Many girls got married during the lockdown in my area.” – Female KI (Teknaf)

Most KIs reported that if children were studying at home at all, it was not very effective. Only households that could afford to employ a home tutor or households with educated family members were able to support their children, while other children received no support.

“People who are solvent, they are continuing their children’s study, keeping a private tutor at home by paying BDT 4,000 to 5,000 a month, which is not possible for poor families. Not all people can afford this. Most of the people in our area depend on the primary school. Children go to school and come back in the afternoon and then if anyone of the parents is educated, they can teach their children at home. Not all have an educated person in their family, so students who are not going to school at present, they are suffering a lot, at least not studying properly at home.” – Male KI (Teknaf)

“Schools remained closed till now due to the lockdown. Families who are solvent, they are teaching their children at home through a home tutor, which is not possible for poor people. Poor families’ children are not receiving any kind of education at present. Children are going to lag behind by two years due to the lockdown.” – Male KI (Ukhiya)

Secondary data indicates that the potential long-term impacts of school closures are very concerning, including that the longer children, especially girls, are out of school, the less likely they are to return.⁴⁸ Overall, only 6% of households with children that previously attended any form of learning reported planning not to send at least one of those children back to its learning opportunities.⁴⁹ However, several KIs indicated that adolescents might be at a higher risk of not being sent back to school, if the lockdown continued, as households would not be able to cover their fees and children would be sent to work instead.

“Problems once schools re-open are that children’s school uniforms and learning materials got unusable. Poor people used to send their children to school, keeping in mind that they would get a stipend, but if now it gets stopped, they may not send their children to school. And also parents may not be willing to send their children out of fear of Corona spreading at school. [...] Poor families can’t manage their families, so they send their children to earn money, so children don’t go school.” – Male KI (Ukhiya)

“If the lockdown continues like this, parents might send male children to work, especially poor families, they would send their children to help with agricultural work. That is normal.” – Male KI (Teknaf)

⁴⁸ United Nations Sustainable Development Group (UNSDG), *Policy Brief: Education during COVID-19 and beyond* (New York, 2020). Available [here](#) (accessed 13 November 2020); The Economist, *School closures in poor countries could be devastating* (Johannesburg, Paris and Sao Paulo, 2020). Available [here](#) (accessed 13 November 2020); The World Bank, *Simulating the Potential Impacts of the COVID-19 School Closures on Schooling and Learning Outcomes: A set of Global estimates* (online, 2020). Available [here](#) (accessed 13 November 2020).

⁴⁹ 747 households (82%) reported children that went to school before the COVID-19 outbreak.

“Though it’s quite tough to say before schools re-open, I can say that for impoverished families sending their children back to school would be a concern, because already children from these families got involved in different types of garment industries in Cox’s Bazar and Chittagong, students of classes 5, 7, and 8. I noticed this in different areas. [...] Parents of grade 7 or 8 students, whose age is 15 or 16, say, as you are not studying and passing idle time at home, now go to work in the garment industry or factory till schools re-open, and they are already having a huge gap in their studies. And this is the case especially for male children, not much for females.” – Male KI (Teknaf)

School closures are also likely to have contributed to an increased exposure of children to protection risks. Households reported in particular child labour to have increased in their communities in the six months prior to data collection, as reported by 49% of households. A further 20% reported an increase in girls under 18 getting married, 7% reported an increase in children experiencing psychosocial distress and 2% each reported an increase in violence against children and/or children going missing. Moreover, households reported a number of protection-related incidents, such as female-headed households and disabled people not being able to meet their basic needs due to a lack of income or livelihood opportunities, which was further compounded by the lockdown, as well as fear of violent groups, e.g. when using bathrooms at night.

At the same time, there seems to be limited awareness or utilisation of existing support structures to report protection incidents to, at least in relation to sexual and gender-based violence (SGBV), with 6% of all households and 13% of households with female respondents reporting that they would not know who to refer a friend to who had been sexually assaulted. Differences between the points-of-contact households with male and female respondents would refer to were fairly pronounced, indicating differing levels of trust in or access to different service providers (see Figure 22). Several KIs in Teknaf emphasised women’s and children’s higher levels of exposure to protection risks and the challenges they face to obtain assistance.

“On the topic of protection, I would say we are still backwards. We experience assault of women and child oppression here. Before it was not much, but after the Rohingyas’ arrival it increased. Here sometimes, when people go to the police station, they ask for money.” – Female KI (Teknaf)

“We women are helpless, we need to depend on our husbands for any decision, we depend on them for money, if we get any support it would be good. Otherwise we don’t have any protection issues. Sometimes problems happen, then people go to the police to file the case. [...] And first people come to us, like ward members or chairmen or village courts. [...] But the problem is that women can’t move independently, as they don’t have income and they depend on their husbands.” – Female KI (Teknaf)

“Women don’t receive proper justice. The police can’t adjudicate their problems, because influential people buy the police by giving them money.” – Female KI (Teknaf)

Erosion of coping capacities

The disruption of livelihoods and exacerbated needs led to an increasing adoption of livelihoods-based coping strategies, including an increase in the adoption of crisis-level coping mechanisms. This suggests an erosion of coping capacities. In 2019, 28% of households still reported not having had to adopt any livelihoods-based coping

strategies due to a lack of money to meet basic needs in the 30 days prior to data collection.⁵⁰ However, in 2020, only 1% reported this, clearly indicating the additional strains the COVID-19 outbreak had put on households. Compared to last year, the proportion of households reporting having borrowed money decreased notably, likely due to a lack of cash within communities following the widespread loss of income, rendering borrowing as a coping mechanism less feasible. As a result, households increasingly reported having spent savings, sold assets, and reduced expenditures, including essential non-food expenditures, such as expenditures on health, clothes or education (Figure 13).

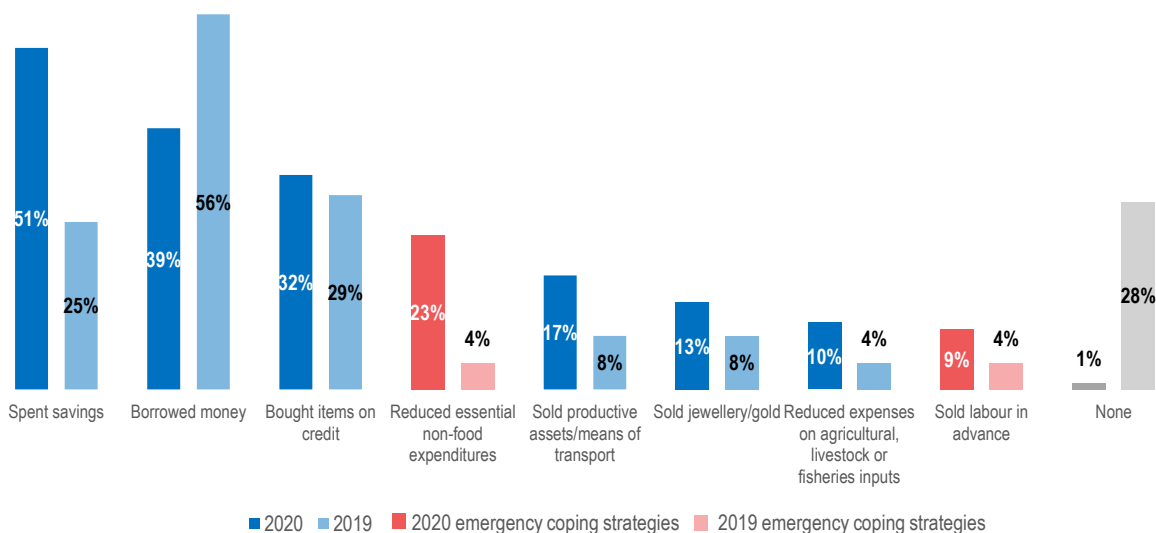


Figure 13 % of households reporting having engaged in coping mechanisms due to a lack of money to meet basic needs in the 30 days prior to data collection

On the one hand, the adoption of emergency coping mechanisms, such as reducing essential non-food expenditures, may have long-term, potentially irreversible negative impacts on individual safety or well-being. On the other hand, also spending savings and selling – in particular productive – assets can have serious implications for households’ ability to fall back on those strategies in the future, while selling productive assets can further have potentially long-term negative impacts on income-earning. As household assets reduce, households become more vulnerable to risks such as a decrease in overall health due to a decreased ability to adopt such coping strategies to seek treatment in the future, increasing food insecurity and malnutrition, and extreme protection risks, such as trafficking, child marriage, eviction, and forced or exploitative labour. Moreover, reduced savings and depleted assets may seriously limit households’ ability to cope with future shocks, as less extreme coping strategies become exhausted. This will render households increasingly vulnerable to the recurrent monsoon damage or other natural hazards, as well as any future lockdowns, and household-level shocks, such as sickness and disease.

Vulnerability

Being less able to absorb shocks, households that were more vulnerable pre-COVID-19 are likely to also have been most vulnerable to the secondary impacts of the COVID-19 outbreak. Households that have often been identified as most vulnerable in the past include female-headed households and households without a male of working age, households with persons with disability (PWDs), and large households (5+ members) (or households with a high

⁵⁰ ISCG, 2019.

dependency ratio (> 2)). Female-headed households or households without males of working age are more vulnerable, as they have substantially less access to income, and face more barriers accessing assistance or basic services due to limited social networks, lower levels of education and language skills, limited working opportunities, increased exposure to sexual and gender-based violence (SGBV), childcare duties, and sociocultural norms, which impact their mobility. Households with PWDs typically spend more money on medical expenses and incur higher levels of debt to pay for those expenses. This leaves them less money to spend on food and other essential items, and increases the adoption of negative coping mechanisms to meet basic needs. Lastly, large households or households with high dependency ratios tend to be more economically vulnerable and have been found in previous studies to be more likely to rely on coping mechanisms, such as borrowing money, to meet essential needs, including for food and healthcare.⁵¹ Those patterns of vulnerability were also reflected in the J-MSNA results.

Households without adult males

With women having less access to job opportunities and income, households without adult males were significantly less likely to report an individual working in the household (Figure 14) and/or to report labour or employment, or an own business as a source of income in the 30 days prior to data collection (Figure 15) than households with adult males. At the same time, several KIs reported that widow- and female-headed households were more at risk of not being able to meet their needs, and one KI specifically linked this to a lack of job opportunities for women in her area as well as limited income women receive.

“There are lots of working opportunities in the garment industry in Dhaka, Chittagong and Cox’s Bazar, but in Teknaf we don’t have any garment factory where women can work. Here women work in betel nut cultivation. Out of 50, 20 women work in this occupation. But after working the whole day, men get BDT 500, but women get only BDT 200. How can a woman run her family with BDT 200 of daily income? In this way, women get discriminated. So women also should be provided BDT 500. Many women are widows who need to manage their family members.” – Female KI (Teknaf)

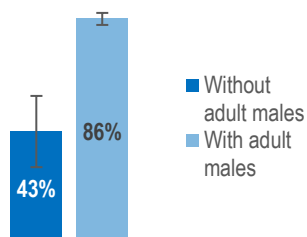


Figure 14 % of households reporting an individual working in the 30 days prior to data collection by presence of adult males (p-value ≤ 0.0001)⁵²

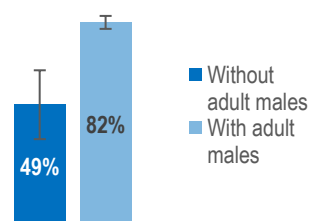


Figure 15 % of households reporting labour/employment and/or an own business as source of income in the 30 days prior to data collection by presence of adult males (p-value ≤ 0.0001)⁵²

This lack of access to cash will certainly impact these households’ ability to meet their basic needs. As such, households without adult males were significantly less likely to report having purchased food using cash, and significantly more likely to report having borrowed food as well as having relied on support from friends or relatives as both food and income sources (Figure 16 and Figure 17), all of which is clearly indicative of a greater lack of self-

⁵¹ ACAPS, ACAPS Thematic Analysis – Bangladesh: Characteristics of vulnerable households in the Rohingya refugee response (Cox’s Bazar, 2020). Available [here](#) (accessed 27 November 2020).

⁵² Results for households without adult males are representative with a +/-14% margin of error (n = 51).

reliance among households without adult males or greater dependence on livelihoods and/or food support to meet food needs.

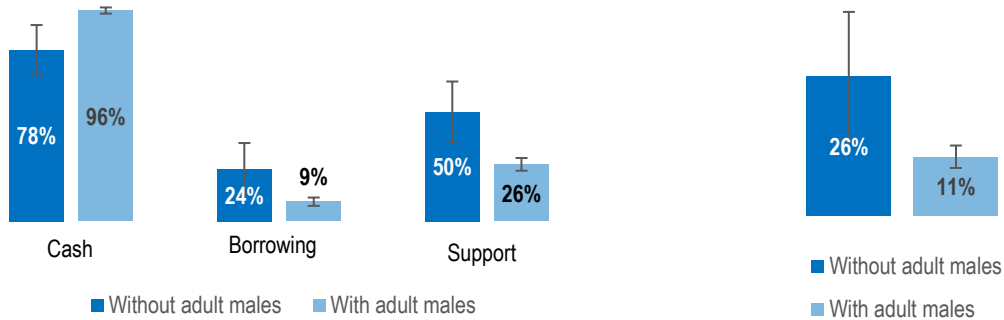


Figure 16 % of households reporting cash (p-value ≤ 0.0001), borrowing (p-value ≤ 0.001), and/or support (p-value ≤ 0.001) as main sources of food in the seven days prior to data collection by presence of adult males⁵³

Figure 17 % of households reporting assistance from relatives/friends as income source in the 30 days prior to data collection by presence of adult males (p-value ≤ 0.01)⁵³

This greater dependence also likely entails a more frequent adoption of coping mechanisms to meet basic needs, with households without adult males having been significantly more likely to report having relied on food rations and/or support from relatives or friends as the only food and income sources as a coping mechanism due to a lack of money to meet basic needs in the 30 days prior to data collection than households with adult males (Figure 18). They were also significantly more likely to report having borrowed food (p-value ≤ 0.05), limited portion sizes (p-value ≤ 0.01) or reduced the number of meals a day (p-value ≤ 0.01) due to a lack of food in the seven days prior to data collection (Figure 19).

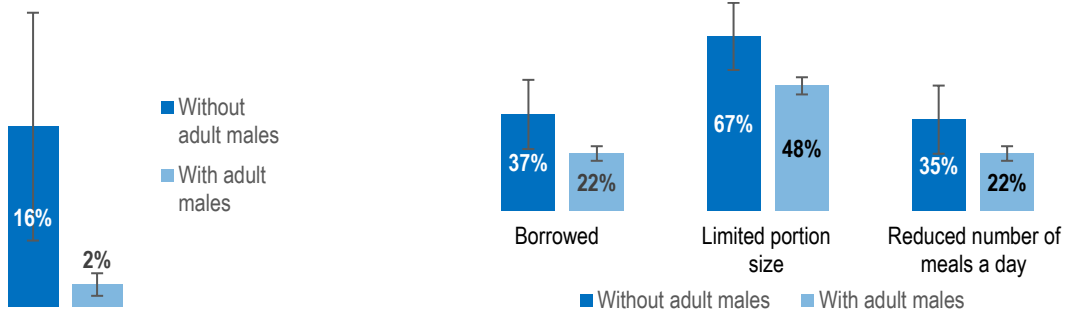


Figure 18 % of households reporting having relied on food rations and/or support from friends/relatives as the only food/income source in the 30 days prior to data collection by presence of adult males (p-value ≤ 0.0001)⁵⁴

Figure 19 % of households reporting having adopted different food-based coping strategies due to a lack of food in the seven days prior to data collection by presence of adult males⁵⁴

The lack of cash to meet essential needs among households without adult males is not only reflected in relation to food needs, but also in relation to other basic needs, such as cooking fuel. While households with adult males were significantly more likely to report having used bought LPG as a source of cooking fuel in the four weeks prior to data collection compared to households without adult males, households without adult males were significantly more likely to report having used self-collected firewood than households with adult males – likely linked to an inability of the former to buy neither sufficient firewood nor sufficient LPG (Figure 20).

⁵³ Ibid.
⁵⁴ Ibid.

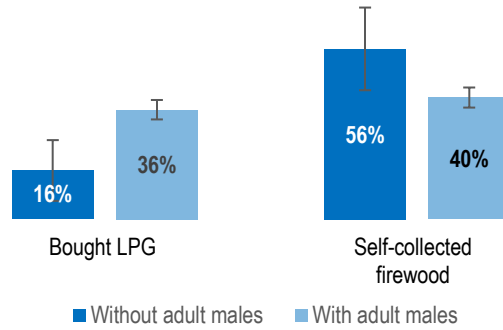


Figure 20 % of households reporting having bought LPG (p-value ≤ 0.01) and/or collected firewood (p-value ≤ 0.05) as a source of fuelwood in the four weeks prior to data collection by presence of adult males⁵⁵

As indicated above, one barrier largely female households face accessing IGAs is related to the limited freedom of movement for women. Overall, households with female respondents more frequently reported that women could go alone to work or to the market than households with male respondents did, but still around half the households with female respondents and the majority of households with male respondents reported that women could not go alone to work or to the market (Figure 21). The generally higher proportion of households with female respondents reporting that women could go to work or to markets alone is likely linked to the fact that roughly half the households with female respondents were female-headed households. In those households, women may travel alone due to a lack of alternatives, but the results still show the severe additional challenges those households would face in meeting needs.

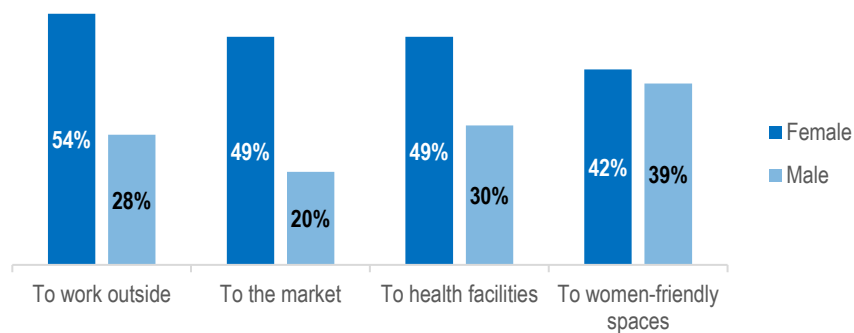


Figure 21 % of households reporting that women can go alone to certain spaces by gender of respondent⁵⁶

The limited mobility of women may also exacerbate the protection risks they are exposed to, as it impedes their access to services outside their home, possibly preventing them from accessing assistance, e.g. at health facilities or women-friendly spaces (WFS). Whether in part related to the limited freedom of movement or other reasons, such as limited trust in support structures, households with female respondents did less frequently report than households with male respondents that they would refer a friend who had been sexually assaulted to official support structures, such as psychosocial service providers, legal aid service providers, health facilities, and/or police and security. They more frequently reported that they would refer them to community-based dispute resolution mechanisms and/or family or relatives, and were also significantly more likely to report not knowing who to refer to at all (p-value ≤ 0.0001) (Figure 22).

⁵⁵ Ibid.

⁵⁶ Results for households with female respondents are representative with a +/-6% margin of error (n = 295).

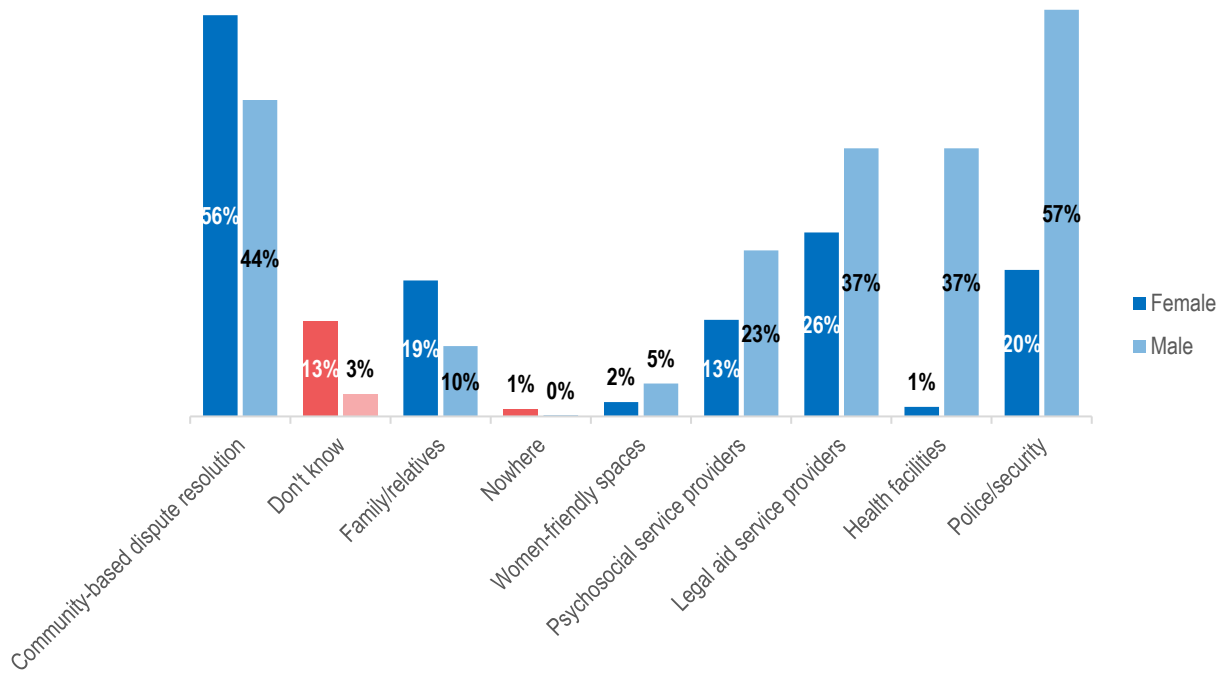


Figure 22 % of households reporting preferred point-of-contact if they needed to refer a friend that had been sexually assaulted by gender of respondent⁵⁷

Moreover, households without adult males were significantly more likely to report having to walk more than one hour to the nearest health facility (Figure 23). Combined with the limited freedom of movement for women, this indicates additional impediments towards seeking healthcare for those households, potentially negatively affecting health and well-being of household members. Furthermore, the challenges and barriers households without adult males may face accessing basic services and meeting needs might have negative consequences for the well-being of children in those households, with households without adult males also having been significantly more likely to report out-of-school children (Figure 24).

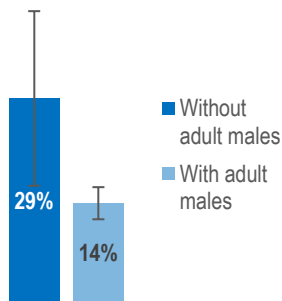


Figure 23 % of households reporting having to walk more than an hour to the nearest health facility by presence of adult males (p-value ≤ 0.01)⁵⁸

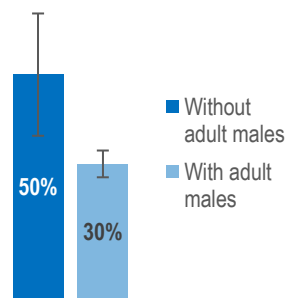


Figure 24 % of households reporting out-of-school children by presence of adult males (p-value ≤ 0.01)⁵⁸

⁵⁷ Ibid.

⁵⁸ Results for households without adult males are representative with a +/-14% margin of error (n = 51)

Lastly, household composition appears to play a role in the interaction with humanitarian actors, with households without adult males having been significantly more likely to report never having been consulted on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak (Figure 25). At the same time, households without adult males were significantly more likely to report not having received clear awareness information on at least one of the topics assessed for this indicator – i.e. cyclone preparedness, early warning and sources of information, and COVID-19 symptoms/vulnerable groups, precautionary measures and points-of-contact (Figure 26). Thus, those households are not only less likely to have their needs and preferences reflected in the design of humanitarian programs, but are also less likely to receive awareness information clear enough to meet their information needs. The latter indicator does not allow to distinguish whether households had not received any information at all or the received information had not been clear. Whether one or the other or both hold true, though, it does show that households without adult males were effectively reached to a lesser degree.

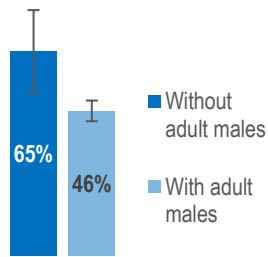


Figure 25 % of households reporting never having been consulted on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak by presence of adult males (p-value ≤ 0.05)⁵⁹

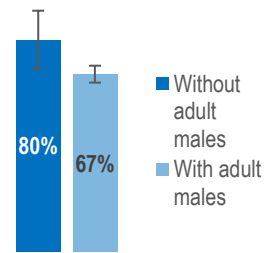


Figure 26 % of households reporting not having received clear awareness information by presence of adult males (p-value ≤ 0.05)⁵⁹

The above might also in part be related to women’s limited freedom of movement, as in relation to reasons for a lack of information on the types of humanitarian assistance available to households, households with female respondents were significantly more likely to report a lack of door-to-door information-sharing as a reason (Figure 27). Thus, potentially also related to awareness messaging, largely female households are less likely to receive messages, if they are not being delivered directly to them.

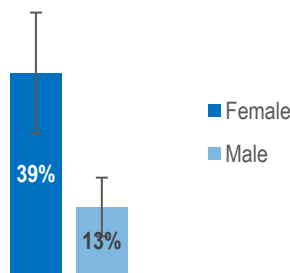


Figure 27 % of households reporting no door-to-door information-sharing as a reason for not having received enough information on different types of humanitarian assistance available to them by gender of respondent (p-value ≤ 0.0001)⁶⁰

⁵⁹ Ibid.

⁶⁰ This question was asked only to households reporting not having received enough information on at least on type of humanitarian assistance available to them. Results for households with female respondents are representative with a +/-12% margin of error (n = 67). Results for households with male respondents are representative with a +/-9% margin of error (n = 136).

Households with PWDs

While the number of households with PWDs included in the assessment was relatively small and therefore results for this group are only representative with a wider margin of error, those households were significantly more likely to report having adopted emergency coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection (Figure 28). They were further significantly more likely to report having adopted food-based coping strategies due to a lack of food in the seven days prior to data collection (Figure 29) and to have relied on food assistance or community support, e.g. borrowing food or buying food on credit, to some degree to obtain food (Figure 30) as well as to have gone into debt to cover health expenses in the 30 days prior to data collection (Figure 31). This confirms the tendency outlined above of those households having to spend more on healthcare and therefore having less resources to cover for other needs, such as food.

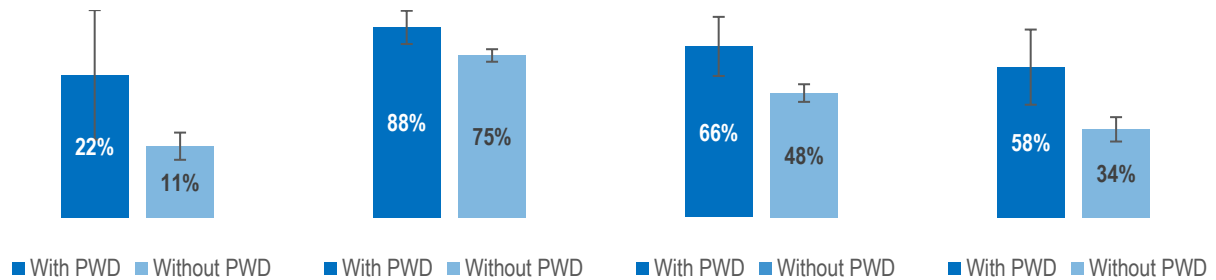


Figure 28 % of households reporting having adopted emergency coping strategies by presence of disabled household members (p-value ≤ 0.01)⁶¹

Figure 29 % of households reporting having adopted food-based coping strategies by presence of disabled household members (p-value ≤ 0.05)⁶¹

Figure 30 % of households reporting having relied on food assistance/community support by presence of disabled household members (p-value ≤ 0.01)⁶¹

Figure 31 % of households reporting having gone into debt to cover health expenses by presence of disabled household members (p-value ≤ 0.01)⁶²

Large households

Lastly, large households were also significantly more likely to report having adopted emergency coping strategies, including the reduction of essential non-food expenditures, having sold labour in advance, depending on food rations and/or support as the only sources of food and income, and/or begging (Figure 32). Furthermore, as reported above, households with high dependency ratios were significantly more likely to report out-of-school children (Figure 5).

⁶¹ Results for households with PWDs are representative with a +/-12% margin of error (n = 67).

⁶² Results for households with PWDs are representative with a +/-15% margin of error (n = 45).

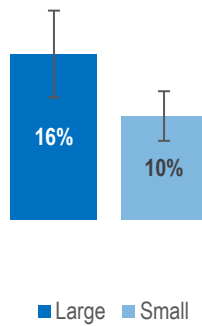


Figure 32 % of households reporting having adopted emergency coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection by household size (p-value ≤ 0.01)⁶³

Differences between upazilas

Not many notable differences in needs and service gaps were found between households living in the two different upazilas. Similar to last year,⁶⁴ the only potential difference found was related to education. A significantly higher proportion of households in Teknaf reported out-of-school children (Figure 33), with a significantly higher proportion of individuals aged 4 to 24 reportedly not having attended any formal learning for at least four days a week in the 30 days prior to school closures due to the COVID-19 outbreak, and a significantly lower proportion reportedly having been enrolled in government schools compared to Ukhiya (Figure 34). At the same time, overall educational levels in Teknaf appear to be lower, with a significantly higher proportion of households reporting only having primary education or less (Figure 35).

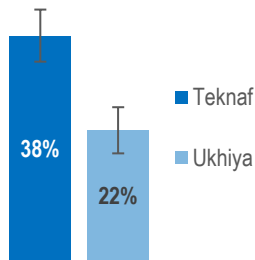


Figure 33 % of households reporting out-of-school children by upazila (p-value ≤ 0.0001)

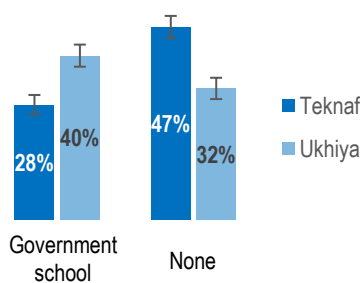


Figure 34 % of individuals enrolled in government schools (p-value ≤ 0.0001) or no formal education (p-value ≤ 0.0001) by upazila

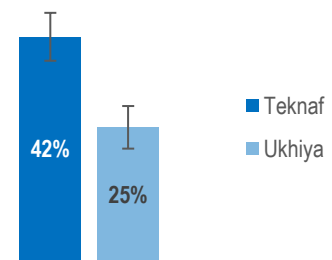


Figure 35 % of households reporting primary education or less as highest level of education in household by upazila (p-value ≤ 0.0001)

Accountability to Affected Populations

With the exception of food assistance, households largely reported not having received enough information on any type of humanitarian assistance since the COVID-19 outbreak, indicating significant gaps in communication with the host communities (Figure 36). The most common reason reported by households for a lack of information was them not having asked for information, as reported by 35% of households. This was followed by information not having been

⁶³ Results for small households are representative with a +/-6% margin of error (n = 300).

⁶⁴ ISCG, 2019.

shared often enough (27%), no door-to-door information sharing (22%), and households not knowing where to get information from and/or not enough information on services having been available, both reported by 18% of households.⁶⁵ As indicated above, a lack of door-to-door information-sharing was reported as a barrier in particular by households with female respondents (Figure 27). The large proportion of households reporting not having received enough information is likely in part at least reflective of limited humanitarian programming in host communities, the latter also being commonly reported by KIs in relation to any sector other than the Food Security Sector.

Generally, KIs suggested to best distribute information via ward members or directly through non-governmental organisations (NGOs), door-to-door or over the phone, but also using microphones, showing videos in different places or institutions/on TV, via elderly respected citizens, the village police, or guards, or through the practice of *uthan boithok* (yard discussions). One KI also suggested Facebook, however, at the same time recognising that this did not allow to reach less educated or illiterate households. The same KI mentioned miking not to always be effective and therefore to prefer to inform beneficiary households in-person.

“My ward consists of three villages. We have the village police and another person to help me. If we receive any support from NGOs, then we circulate the information. If we use Facebook, illiterate people can’t understand and access the information. Even miking has a negative impact. If we announce through the mike that one NGO is providing support for 50 specific people, then many people also join the distribution centre, which creates a big chaos. And also sometimes people don’t get the miking announcement if they sleep or are busy working. That’s why we send our representative to those households who we select for receiving support to collect their information and later distribute to them.”

– Male KI (Teknaf)

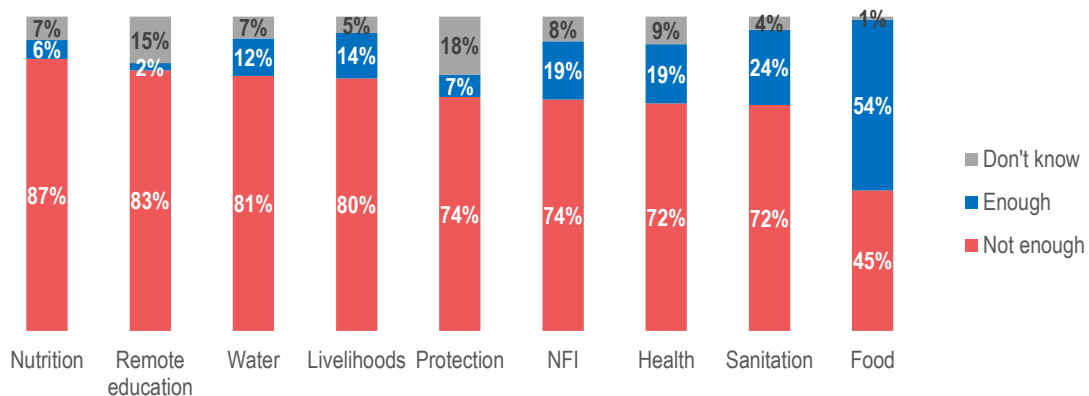


Figure 36 % of households reporting having received enough information about humanitarian services/types of assistance since the COVID-19 outbreak⁶⁶

Levels of satisfaction with humanitarian assistance since the COVID-19 outbreak and since the beginning of the year and before the COVID-19 outbreak were similarly low, with the highest proportion of households reporting that services had not gone well in relation to nutrition (reported not to have gone well since the COVID-19 outbreak by 32% and before the COVID-19 outbreak by 28% of households) and shelter assistance (reported by 32% and 31% of households not to have gone well since and before the COVID-19 outbreak, respectively). Figure 37 shows the ten services with

⁶⁵ This question was only asked to households reporting not having received information on at least one type of humanitarian assistance. Results are representative with a +/-7% margin of error (n = 203).

⁶⁶ This question was only asked to households having received humanitarian assistance. Results are representative with a +/-7% margin of error (n = 217).

the highest proportion of households reporting that they had not gone well since the COVID-19 outbreak. Other services that appeared in the top ten services not having gone well before the COVID-19 outbreak but had not been continued since included livelihood skills training (reported not to have gone well by 28% of households), education and environmental restoration, reported not to have gone well by 25% of households each, and access to safe spaces for children (24%).⁶⁷

A comparison of levels of satisfaction between male- and female-headed households or households with and without adult males was not possible due to limited sample sizes. However, comparing levels of satisfaction as reported by households with male and female respondents shows that households with female respondents more frequently reported not having received different types of assistance, while households with male respondents more frequently reported not having been satisfied. With roughly 50% of households with female respondents having been male-headed, this may in part be related to females in male-headed households not being the ones receiving the assistance, and potentially being less aware of the types of assistance the household received. For female respondents of female-headed households or households without adult males, this may, however, also be an indication of those households having less access to humanitarian assistance – with female-headed households or households without adult males generally showing the same patterns, but with response rates too low to be presented here.

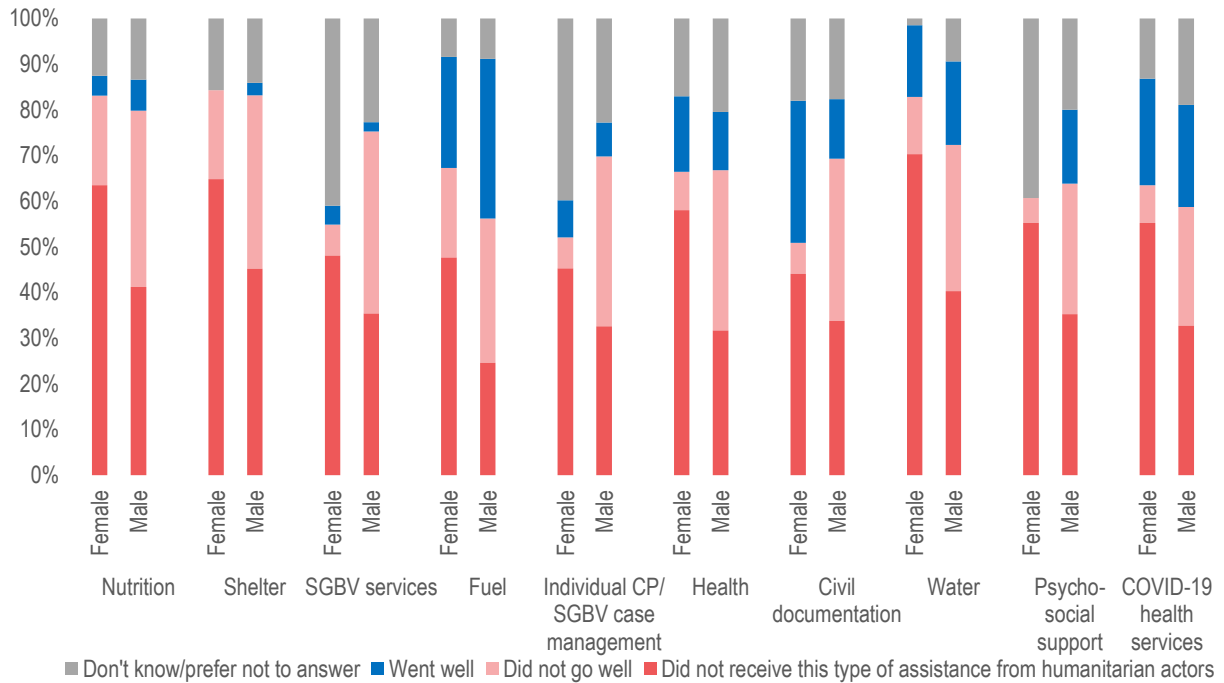


Figure 37 % of households reporting satisfaction with assistance since the COVID-19 outbreak by gender of respondent⁶⁸

⁶⁷ Ibid.

⁶⁸ This question was only asked to households that had received any humanitarian assistance in the past 6 months. Results for households with female respondents are representative with a +/-12% margin of error (n = 71). Results for households with male respondents are representative with a +/-9% margin of error (n = 146).

CONCLUSION

The District of Cox's Bazar, located in southern Bangladesh, faces some of the poorest living conditions in the country. At the same time, almost 900,000 Rohingya refugees continue to reside in camps in Ukhiya and Teknaf Upazilas. While needs in Ukhiya and Teknaf mainly arise from existing development challenges, they may have been compounded by the refugee influx, and with the refugees unlikely to return to Myanmar in the near or medium term, there is a continued need for up-to-date information on the needs and vulnerabilities of all affected populations. At the same time, the COVID-19 outbreak and associated containment severely disrupted livelihoods, likely having exacerbated needs. Against this background, this J-MSNA was conducted to support detailed humanitarian planning and enhance the ability of operational partners to meet the strategic aims of donors and coordinating bodies. More specifically, the J-MSNA aimed to assess current levels of need and service gaps among host community populations, in particular within the context of the COVID-19 pandemic and including a basic understanding of inter-household differences in outcomes. The assessment covered host community populations residing in Teknaf and Ukhiya Upazilas, and was implemented through the ISCG's MSNA TWG.

Findings show that needs most prioritised by households included access to food, access to cash and shelter materials, likely reflecting the impact of the COVID-19 pandemic on food security and livelihoods.

Certain needs and service gaps that had already existed pre-COVID-19 remained unchanged. Roughly a fourth of households reported not having made any improvements to their housing in the six months prior to data collection despite having reported issues, largely due to a lack of money to pay for materials and/or labour. Over 40% of households reportedly used purchased and/or self-collected firewood as a source of cooking fuel in the four weeks prior to data collection, with only 26% reporting having used exclusively LPG. With regards to drinking water, 23% of households reported not having enough water to meet all domestic needs and several KIs reported water quality to be an issue. Furthermore, the proportion of households with PLWs reporting PLWs to be enrolled in nutrition-feeding programmes remained low (12%), as did the proportion of children aged 6 to 59 months reportedly being enrolled in nutrition-feeding programmes (15%). Moreover, 31% of households reported out-of-school children, with less educated households and those with high dependency ratios having been significantly more likely to report out-of-school children. Lastly, almost half the households reported never having been consulted on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak, and also clear awareness messages, in particular in relation to cyclones, were only partially received.

The COVID-19 outbreak and associated containment measures severely disrupted income-earning and considerably reduced households' levels of income compared to pre-COVID-19 levels. Likely linked to reduced levels of income, by July, FCS had dropped considerably compared to last year, with a doubling in poor FCS from 4% to 8%, and a drop in acceptable FCS from 72% to 43%. The overall high proportion of households reporting having adopted food-based coping strategies in the seven days prior to data collection due to a lack of food (76%) is further indicative of food shortages and consumption gaps. In addition, overall health outcomes may have been negatively affected by the impact of the COVID-19 outbreak on health-seeking behaviour. The proportion of individuals reported sick enough to require medical treatment dropped from 31% in 2019 to 14% in 2020, likely reflecting a drop in the proportion of individuals that sought treatment when they should have, and thus a reduction in health-seeking behaviour. Lastly, child protection issues reportedly increased since the lockdown, in particular child labour, which was reported to have increased in

communities by almost half the households (49%). School closures in mid-March 2020 possibly in part contributed to this increase.

Rising levels of need, coupled with reduced levels of income likely increased the adoption of livelihoods-based coping strategies, including crisis-level coping mechanisms. As households were less able to rely on previously common coping strategies, such as borrowing money, they increasingly eroded assets and savings, and adopted more crisis-level strategies. Such an erosion of coping capacities will render households more vulnerable to future shocks as well as a possibly continued disruption of assistance and lack of access to livelihood opportunities. It can further be expected to have negative repercussions on access to healthcare, food security and nutrition as well as household exposure to extreme protection risks.

Households that were more vulnerable pre-COVID-19 are likely to also have been most vulnerable to the secondary impacts of the COVID-19 outbreak. These households include female-headed households or households without a working-age or adult male, households with PWDs, and large households or households with high dependency ratios. Households without adult males face more challenges accessing job opportunities due to socio-cultural norms and other constraints that limit women's freedom of movement and possibility to access IGAs. These households were therefore characterised by higher levels of dependence on assistance or support from others to meet basic needs, such as food needs, and were significantly more likely to report having adopted a number of food-based coping strategies due to a lack of food in the seven days prior to data collection as well as having relied on food rations or support from family or friends as the only sources of food and income due to a lack of money to meet basic needs in the 30 days prior to data collection. In addition, largely female households may face greater challenges accessing protection services, health facilities and supporting children's education, as well as interacting with humanitarian actors and receiving information. Households with PWDs were also significantly more likely to report having adopted emergency as well as food-based coping strategies. Lastly, large households were significantly more likely to report having adopted emergency coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection as well.

Given the exacerbated needs and the erosion of coping capacities, as well as the quickly changing levels of need that can be expected as the pandemic evolves and humanitarian programming continues to be adapted, in the near and medium term, it will be of great importance to continue to closely monitor needs and service gaps to allow for continued evidence-based programming. The results of the J-MSNA are characteristic of the very specific circumstances that prevailed at the time of data collection. As the situation changes, especially the most concerning trends uncovered by the findings, including in relation to food security, health-seeking behaviour and likely accompanying adverse impacts on health, education, and child as well as general protection risks should be closely monitored.

Given the scope and practical limitations of this assessment, information gaps persist. First, additional information on the impact of the lockdown on levels of security, protection-related incidents and their impacts on household and individual well-being may support effectively countering negative trends. Secondly, a better understanding of the impacts of the COVID-19 outbreak and containment measures on the most vulnerable households may help more effectively alleviate those. Both will require carefully designed in-person data collection.

In the long term and in the context of future MSNAs, a more comprehensive assessment of key barriers to accessing different types of services faced by different groups of households and individuals may contribute to reducing persisting vulnerabilities in the long run.

ANNEXES

Annex 1: Household surveys completed per union

Table 1 List of surveys completed per union against union population and targeted minimum number of surveys

Upazila	Union	Total number of households	Targeted minimum number of surveys	Completed number of surveys
Ukhiya	Raja Palong	10,596	106	144
	Haldia Palong	9,006	90	34
	Jalia Palong	8,511	85	113
	Ratna Palong	4,238	42	65
	Palong Khali	5,589	56	86
Teknaf	Nhilla	8,271	70	90
	Sabrang	9,970	84	107
	Whykong	8,867	75	91
	Bharchhara	4,832	41	60
	Teknaf (incl. Paurashava)	13,219	112	121
Total		83,099	761	911

Annex 2: Key informant interviews completed by gender and union

Table 2 List of key informants completed per camp, overall and by gender of respondent

Upazila	Union	Female	Male	Total
Ukhiya	Raja Palong	-	-	-
	Haldia Palong	-	-	-
	Jalia Palong	1	3	4
	Ratna Palong	-	-	-
	Palong Khali	1	3	4
Teknaf	Nhilla	2	2	4
	Sabrang	-	-	-
	Whykong	1	2	3
	Bharchhara	2	2	4
	Teknaf Sadar	3	1	4
	Teknaf Pourashava	-	-	-
Total		10	13	23

Annex 3: Agenda of enumerator training

Figure 38 Agenda of enumerator training (for both host community and refugee survey)

AGENDA			
Multi-Sector Needs Assessment Training, July 2020			
(jointly facilitated by UNHCR/REACH)			
Purpose/Overall aim –			
To enable, strengthen and improve the skills and capacity of enumerators to be able to conduct data collection for multi-sector needs assessment to a high quality and ethical standard.			
Learning outcomes –			
<ul style="list-style-type: none"> - Understanding of the, objectives and purpose of the multi-sector needs assessment - Knowledge and understanding of research ethics (confidentiality, informed consent, do no harm) - In-depth understanding of questionnaires 			
Timing –			
<ul style="list-style-type: none"> - Please note that the timing will be: 8:30 am start and 5:30 pm finish. - Two 15 minute breaks and one (1 hour) lunch break will be given across the day. - Agenda time is a guide only. Training venue- Hangouts/Skype 			
Date & Time	Session	Objectives	Facilitator
Training Day 1, 16 July 2020 (Thursday)			
08:30-9:30 am	Registration Hangouts/Skype connection trial	Ensure flexibility of doing online training session	REACH
9:30-10:45 am	Team Formation (Icebreaker/Activity)	Develop a team bonding	REACH
10:45-11:00 am	Tea break		
11:00-11:30 pm	Introduction to <u>KoBo</u> Collect	Articulate key facts of Kobo using	UNHCR
11:30-12:15 pm	Explanation- Role of FC, FA, TL, Enumerator	Understanding roles	REACH
12:15-1:00 pm	Data collection instructions	Understanding allocation of phone numbers, call-back procedures, etc.	REACH
1:00 -2:00 pm	Lunch break		
2:00 – 3:45 pm	Language training	Improves <u>Chittagonian/Rohingya</u> speaking and reading	REACH
3:45 - 4:00 pm	Tea break		
4:00 – 5:30 pm	Continuation of language training (if needed)	Improves <u>Chittagonian/Rohingya</u> speaking and reading	REACH
<i>End of Day 1</i>			
Training Day 2, 19 July 2020 (Sunday)			
8:30-9:00 am	Registration		
9:00-9:15 am	Welcome & Introduction, Learning objectives, Learning Agreement for the day	Understand purpose, objectives and agenda of the training Establish a learning agreement	REACH
9:15-9:45 am	Overview of research objectives and scope	Familiarize research teams with research objectives	REACH
9:45-10:45 am	Research ethics and code of conduct	Summarise the outline of core research principles (including AAP, PSEA, referrals)	UNHCR
10:30-10:45 am	Refresher on methodology	Understanding basic research principles, random sampling	REACH
10:45-11:00 am	Tea break		

11:00-11:30 am	Introduction to Phone Interview (guidance, challenges), Do's and don'ts of good interviewing	Identify challenges in surveying over phone call and positive communication that supports a safe and comfortable interview	UNHCR
SPLIT INTO TWO DIFFERENT GROUPS			
11:30-12:30 pm	Introduction to questionnaire (Hard copy)	Opening part of the questionnaire (informed consent, basic information of HH)	REACH
12:30 – 1:00 pm	Shelter/NFI (refugee) / Health (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
1:00-2:00 pm	Lunch break		
2:00-2:30 pm	Education (R) / Nutrition (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
2:30 – 3:00 pm	Health (R) / Food security/Livelihoods (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
3:00 – 3:30 pm	Nutrition (R) / WASH (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
3:30 – 3:45 pm	Open questions	Clarification of any open questions	REACH
3:45-4:00 pm	Tea break		
4:00-4:30 pm	Food security/Livelihoods (R) / Protection (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
4:30 – 5:00 pm	WASH (R) / Gender (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
5:00-5:30	Open platform for questions	Clarification of any open questions	REACH
<i>End of day 2</i>			
Training Day 3, 20 July 2020 (Monday)			
8:30-9:00 am	Registration		
9:00-9:15 am	Learning objectives, Learning Agreement for the day	Develop clear participant expectations Establish a learning agreement	REACH
9:15-9:45 am	Gender (R) / CWC/AAP (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
9:45 – 10:15 am	Protection (R) / Education (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
10:15 – 10:45 am	CWC/AAP (R) / Shelter/NFI (HC)	Question-by-question review of questionnaire, clarification of any issues	REACH/sectors
10:45-11:00 pm	Tea break		
11:00-1:00 pm	Questionnaire review using Kobo tool	KOBO form review	REACH
1:00-2:00 pm	Lunch break		
2:00-3:00 pm	Questionnaire review using Kobo tool	KOBO form review	REACH
3:00-3:45 pm	Mock interview session (small group calls between enumerators with team leader feedback within their small groups)	Exercise questionnaire with Kobo form	REACH
3:00-3:45 pm	Tea break		
4:00-5:00 pm	Continuation of mock session	Exercise questionnaire with Kobo form	REACH
5:00-5:30 pm	Open platform for questions	Clarification of any open questions	REACH
<i>End of day 3</i>			

Training Day 4, 21 July 2020 (Tuesday)			
8:30-9:00 am	Registration		
9:00-9:30 am	Comprehension testing of key phrases	Test ability to recognize perplexing words	REACH
9:30-10:45 am	Continuation of mock session	Exercise questionnaire with Kobo form	REACH
10:45-11:00 am	Tea break		
11:30-12:00 pm	Review with the whole group	Clarification of open questions	REACH
12:00 – 1:00 pm	Continuation of mock session	Exercise questionnaire with Kobo form	REACH
1:00-2:00 pm	Lunch break		
2:00-2:30 pm	Feedback from test	Ensure understanding of key phrases	REACH
2:30-3:45 pm	Continuation of mock session	Exercise questionnaire with Kobo form	REACH
3:45-4:00 pm	Tea break		
4:00-4:30 pm	Review Day 1, Day 2	Refreshed memory on day 1 and day 2	REACH/UNHCR
4:30-4:45 pm	Logistics for pilot days	Check availability of mobile, enough mobile recharge	REACH
4:45-5:30 pm	Open platform for questions	Clarification of any open questions	REACH
<i>End of day 4</i>			
Day 5, 22 July 2020	Pilot data collection		REACH
Day 6, 23 July 2020	Pilot review	Review of pilot, clarification of any open questions	REACH

Note: The first half of the Day 1 training will be for all enumerators, while the language training will only be for those conducting interviews in camps. Similarly, the first half of the Day 2 training day will be held with all enumerators together, and from the second half of the first day they will be split into two separate trainings for refugee and host community data collection.

Annex 4: Partners involved in the assessment

Table 3 List of partners involved in each stage of the assessment

Stage of the assessment	Partners involved
Research design	MSNA TWG, led by the ISCG and comprised of UNHCR, IOM NPM, ACAPS and REACH
Tool design	Sector partners, MSNA TWG
Enumerator training	Sector partners, UNHCR, REACH
Data collection	UNHCR, IOM NPM, REACH
Data cleaning, transcription and translation	REACH
Data analysis	MSNA TWG, Sector partners
Secondary data review	ACAPS
Dissemination	MSNA TWG



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