

‘People won’t die due to the disease; they will die due to hunger’: Exploring the impacts of covid-19 on Rohingya and Bangladeshi adolescents in Cox’s Bazar

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Introduction

Since reporting the first case of covid-19 on 8 March 2020, the World Health Organization (WHO) has confirmed 299,628 cases and 4,028 related deaths in Bangladesh as of 26 August 2020 (WHO, 2020b). As a district, Cox’s Bazar remains exposed: it encompasses two registered and 32 unregistered Rohingya camps that are home to nearly 1 million refugees residing in cramped conditions, alongside impoverished host communities where thousands of vulnerable Bangladeshis live. This environment puts the population at extreme risk of an outbreak (Khan, Islam and Rahman, 2020; Islam, Inan and Islam, 2020; Islam and Yunus, 2020). In Cox’s Bazar, the Institute of Epidemiology, Disease Control and Research (IEDCR) has confirmed 3,906 cases (IEDCR, 2020) and the Inter-Sector Coordination Group (ISCG) weekly bulletin published on 20 August 2020 reports 79 confirmed covid-19 cases in the Rohingya camps (ISCG, 2020). Though the scale-up of testing capacities has seen documented cases rise, testing remains limited and heavily concentrated in Dhaka, thus the



magnitude of the virus' spread is likely to be underreported (Vince, 2020). This is particularly evident in the camps, where the WHO reported that by 19 August 2020, a total of 22,484 covid-19 tests had been conducted in host communities compared to 3,176 in the camps (WHO, 2020a).

GAGE's previous research in Cox's Bazar, nested within the larger Cox's Bazar Panel Survey (CBPS)² has found that both Rohingya and Bangladeshi adolescent girls and boys face a multitude of challenges including gender- and age-based violence, severed educational prospects for older adolescents in particular, widespread psychosocial distress and worry, and limited health service uptake (GAGE et al., 2020; Guglielmi et al., 2020a, 2020b, 2020c, 2020d). In the camps, the nationwide shutdown of educational institutions on 16 March 2020, coupled with the mandated lockdown on 24 March 2020 to mitigate the spread of covid-19, saw the closure of learning centres, Child and Adolescent Friendly Spaces, and other protective environments, which is forecast to have negative impacts on educational attainment and increased exposure to child protection risks such as sexual exploitation, child labour, neglect, and physical and emotional abuse that could negatively affect child development, especially in adolescent girls (UN Women, 2020b). In host communities, there is widespread concern about both the health and economic repercussions that prolonged lockdown will have and the World Food Programme (WFP) has reported that covid-19 has 'severely impacted the food security and livelihoods situation of the population compounded by market fluctuations' (WFP, 2020: 3).

Other research focusing on adults in the CBPS has documented that covid-19 symptoms are common among the population, with attendance at religious and social events threatening to exacerbate its spread (Lopez-Pena et al., 2020). Moreover, they document that food insecurity and the inability to purchase essential foods may be a potential determinant of susceptibility to the disease (ibid).

In order to inform the Bangladeshi government's response and that of its humanitarian and development partners in Cox's Bazar, it is essential to supplement the existing evidence base with a focus on adolescent girls and boys, given the likelihood that containment measures will have multidimensional effects on young people's well-being in the short and medium term. This policy brief draws on virtual research findings carried out with adolescent girls and boys in May and June 2020 and also presents priority policy and programming implications.

Methodology

This policy brief is part of a cross-country series designed to share emerging findings in real time from quantitative surveys and qualitative interviews with adolescents³ in the context of covid-19. The young people involved are part of the Gender and Adolescence: Global Evidence (GAGE) programme's longitudinal research in the Middle East, East Africa and South Asia and our sample includes two cohorts: younger adolescents (10–14 years) and older adolescents (15–19 years).

To inform the pandemic response and contribute to efforts aimed at ensuring that gender- and age-specific experiences are taken into account, other social characteristics (including disability, refugee status, marital status) are also captured in our sample. The aim of our research is to report disaggregated findings by gender, age and other intersecting dimensions. Where no meaningful differences exist by gender or age, these dimensions are not specified and we refer to 'adolescents'. This brief reports findings from Cox's Bazar, where a sample of 725 Rohingya adolescents living in camps and 1,097 Bangladeshi adolescents living in host communities were surveyed from May–June 2020. A total of 30 adolescents were engaged via in-depth qualitative virtual interviews. Seven key informant interviews were also conducted with education, public health and site management field experts in the camps to understand the measures taken by the government, UN and NGOs in response to the ongoing pandemic. See Table 1 for the sample breakdown.

Table 1: Virtual research sample

	Quantitative fieldwork		Qualitative fieldwork	
	Fieldwork sites	No. of respondents	Fieldwork sites	No. of respondents
Refugee camps	32	725	3	28
Host communities in Teknaf and Ukhia	57	1,097	2	9
Total	89	1,822	5	37

Our findings present a set of indicators constructed from the quantitative data to capture the breadth of experience of Rohingya and host community adolescents, exploring differences by gender, age and location. To analyse the qualitative data, transcripts were translated and then coded following a thematic codebook shaped around covid-19 knowledge, perceptions and behavioural responses and the GAGE conceptual framework.

What do young girls and boys know about covid-19?

Symptoms and prevention

While all adolescents have heard of covid-19, our qualitative data finds that some adolescents – married girls primarily – have limited information on the disease. A 17-year-old married girl in site 1 noted: *'There is a disease. But I don't know much about it. I just heard from the people here. I didn't see it with my own eyes ... I don't know [the name of the disease],'* and a 19-year-old married girl from site 1 said, *'I don't know the name [coronavirus]. I don't know anything, as I don't go out. [Even before] I never went out of the house.'*

Across camp and host community locations, both our quantitative and qualitative data found that adolescents who had heard about covid-19 could mention accurate symptomology. Some 77% of adolescents identify either coughing (41%) – mostly dry cough (25.4%) – or fever (35%) as the most important symptoms, and the majority of qualitative respondents also mentioned coughs and fevers. The qualitative findings did point to occasional erroneous information on symptoms and preventative measures circulating among adolescents. A 17-year-old married girl from site 1 explained, *'We boil water to drink now'*; a 17-year-old boy site 1 claimed, *'[We] can get infected by sitting over insects ... People infected die within 14 days'*; and a 15-year-old female in site 1 explained, *'I've seen the hair of the infected person falls [they are] bald ... Their body swells, they become mad, their body almost curved.'* Moreover, the qualitative data underscores that many adolescents believe catching covid-19 will lead to certain death. Notwithstanding the existence of misinformation, data from our quantitative survey shows that 74% of adolescents know that covid-19 can be spread without symptoms.

Mixed methods data showcases that the most commonly mentioned measure of prevention is hand washing – with 44% of adolescents washing their hands at least five times per day and 40% of qualitative interviews mentioning doing this for more than 20 seconds. Staying at home and maintaining social distance, ideally at least *'three hands⁴ away from people'* (15-year-old male, site 2) were also commonly mentioned. Quantitative data suggests that 95% of adolescents said they wear a face mask to protect against coronavirus, although observational data from IPA Bangladesh suggests that these self-reports may overestimate the reality.

The strict enforcement – including via physical force from the police – of stay-at-home orders and mandatory wearing of face masks while going out in public has impacted normative adherence. A 19-year-old married girl in site 1 explained, *'[Men] wear masks. Police will hit people if they don't wear [them].'* While gender differences in wearing face masks are not statistically significant in the camps, the largest gender difference is found in host communities, where Bangladeshi boys are more likely to wear face masks compared to girls (98% vs 92%, $p < 0.1$). This mostly stems from the fact that Bangladeshi adolescent girls reported barely going out of the house at all, while boys reported going out albeit with more restrictions than prior to the pandemic. Sometimes boys leave to meet their friends, circumventing the gaze of security forces. An adolescent boy living with a disability said, *'If we hear soldiers are coming, we leave the spot instantly ... we don't go out in presence of them. Otherwise, we go out'* (14-year-old male, site 5).

In terms of abiding by preventative measures, adolescents in host communities were more likely to have stayed at home in the last seven days compared to Rohingya adolescents, although this amounted to less than half our sample in either location (38% stayed at home in the last seven days in camps and 44% in host communities). Our quantitative data highlights gender differences in both locations, with girls being significantly more likely to stay at home than boys (68% of girls vs 15% of boys reported staying at home in the seven days preceding the survey). In both camps and host communities, the most common reasons for leaving the home in the seven days prior to the survey were to buy food and to attend a religious service (26% of adolescents left the house for one or other of these occurrences) and boys were more likely to be the ones to leave.

Sources of information

Sources of information for the adolescents in our sample vary. The most common sources of information on covid-19 in the camps are informational campaigns on the street also referred to as 'miking', whereby a mobile vehicle carrying a loudspeaker announces information (30% of adolescents report receiving information in this way); hearing from

▶ I don't know the name [coronavirus]. I don't know anything, as I don't go out. [Even before] I never went out of the house.

(A 19-year-old married girl from site 1)

friends/neighbours/acquaintances (reported by 25% of adolescents); and being informed by NGOs (reported by 22% of adolescents). Qualitative data showcases that the latter may take several forms with site volunteers travelling door-to-door to share information and NGOs organising meetings. A 17-year-old married girl explained, *'Some people came to give information. They gave us soap and cloth to wash our hands. They told us to stay neat and clean, not to be dirty. They gave us the cloth to clean our hands three times a day. Not to eat or touch anything without washing hands ... I'm doing everything as they told us. Allah is blessing us. They are the volunteers,'* while an 18-year-old boy living with a disability explained, *'Some visitors came and told me to maintain distance, wash hands with soap, wear a mask, to stay away, all these things. A person from an NGO came in my house.'* Adolescents mentioned that while 'miking' had been prominent during the initial outbreak of covid-19 and in the first weeks of lockdown, it has since dissipated, and they are left without a steady stream of information. Rohingya adolescents do not have television at home, yet boys and men used to gather at local shops or tea-stalls to watch television. With covid-19, this practice is now forbidden. A 15-year-old Rohingya boy from site 3 said, *'I used to watch TV in a local shop. When the police come, they don't let us watch TV there since at the time of news telecasting, a lot of people gather over there.'* In qualitative interviews, adolescents in host communities reported watching television either at home or at a neighbour's house.

Rohingya adolescents mentioned that due to the prolonged internet shutdown across the camps, they cannot access online news or use social media. While a minority of adolescents mentioned finding creative ways to go online, *'I use Facebook somehow going up on the hill'* (18-year-old male, site 2), many more adolescents described how compounding factors related to not owning a personal mobile phone and internet suppression in the camps had created gaps in their information flow. Conversely, adolescents in host communities mentioned getting news from YouTube, Google and Facebook.

How have adolescents been affected by the government's response to the pandemic?

Education and learning

In host communities, 75% of adolescents were enrolled in formal school before covid-19 and while we report no significant gender differences, young-cohort adolescents were 33 percentage points more likely to be enrolled than older adolescents (91% vs 57%). Opportunities for school-going adolescents to continue learning during school closures appear limited: 6% report that their school is providing learning support, 14% report having been in contact with a teacher in the seven days prior to data collection, and 6% report using internet or media sources to continue distance learning. However, 76% of our school-going sample has reported receiving family learning support during school closures, though boys are more likely to receive such assistance compared to girls (82% vs 71%). School closures are adversely impacting Bangladeshi adolescents' well-being, as described by an 18-year old girl in site 5: *'As I can't go to college now, I feel very suffocated,'* and a 15-year-old boy in site 5: *'I think I would feel better if educational institutions were open because I feel bored.'*

In the camps, 29% of the adolescents in our sample were enrolled in non-formal school before covid-19 with significant gender and age differences.⁵ Boys were twice as likely to be enrolled than girls (39% vs 19%) and young adolescents were three times as likely to be enrolled than their older counterparts (43% vs 15%). With regards to education, although Rohingya girls are disadvantaged irrespective of age, their marginalisation from learning intensifies as they age through adolescence. In the old cohort, only 5% of girls are enrolled compared to 25% of boys. In the young cohort, they are a little over half as likely to be enrolled (33% vs 51%). Across gender and age, while less than 1% of adolescents enrolled in informal school report using the internet or media to continue learning, 70% reported receiving family support for learning. Among the enrolled population in our sample, Rohingya adolescents are hopeful about resuming school, with only 5% worrying about not returning even when restrictions end. The closure of learning facilities in the camps has affected adolescents' younger siblings, as a 17-year-old boy in site 2 explained: *'Now there are many difficulties in education in the camp. While studying in class 1 and class 2, the children's year is over. Previously they were tested at the end of the year. Now [this won't happen] either.'*

Rohingya adolescents were twice as likely to be engaged in religious education prior to the outbreak of covid-19 compared to Bangladeshi adolescents (24% and 13% respectively) with important gender and age distinctions. In camps, Rohingya boys are nearly twice as likely to be enrolled than girls (30% and 17%) with the majority of enrolled students across both genders in the young cohort (39% vs 8%). Our qualitative data shows that when boys enrolled in religious education were interviewed, they lamented the loss of learning opportunities due to the closures and this negatively impacted their well-being. A 15-year-old boy in site 2 crystallised this sentiment: *'I do study. Since the mosque-madrassa*

Since the mosque-madrassa cannot be opened, as the government has closed it, I am not able to study [now]. That's why a lot of sadness is in my mind.

(A 15-year-old boy in site 2)

cannot be opened, as the government has closed it, I am not able to study [now]. That's why a lot of sadness is in my mind. With regards to job or skills training courses, survey data reveals that 2% of Rohingya adolescents are engaged in such courses, and girls are more likely to be engaged in skills training than boys (3.7% compared to 0.3%). Likewise, girls are more likely to be engaged in skills training than boys, although overall numbers remain very low with 1% of boys and 1.5% of girls reporting engagement.

Finally, school closures appear to have impacted the amount of time adolescents in both host communities and camps spend on household chores and childcare. Across locations, 93% of adolescents, regardless of age or gender, reported an increase in time spent in chores and childcare. Our qualitative data, however, does underscore gender divides, with adolescent girls in host communities especially mentioning an increase in household chores and helping their mothers. A 15-year-old girl in site 4 stated, *'Everyone just sits at home ... We cook and feed the men at home,'* while an 18-year-old in site 5 explained, *'[The] household work has increased from earlier ... We help our mother in cooking; we take care of our youngest sister who is two years old.'* Only one Bangladeshi adolescent boy explicitly talked about helping at home, *'Before we all were busy with own works. My younger brother and I used to go to school. My mother used to do household work. But now we all do housework together.'*

Bodily integrity

Across locations, 8% of adolescents reported an increase of gender-based violence (GBV) in the community during the pandemic. Boys specifically report concerns around escalation in police and military violence when enforcing lockdown measures (38% of boys vs 22% of girls). Qualitative data highlights that socio-cultural mobility restrictions placed on older Rohingya girls primarily explain why they are less likely to encounter police abuse, as they frequently remain inside their homes – even prior to covid-19. An 18-year-old married girl explained, *'[I didn't go out of home earlier and] I don't go out now either. [My husband] goes to the nearest shop and has conversations with people sometimes. He can't go to the big bazar of the camp. There are soldiers there ... They hit people if they see anyone in the big bazar,'* while a 15-year-old girl in site 1 explained, *'The army hit people if they go out and if they don't wear a mask.'*

Box 1: Child marriage and covid-19

Our data points to mixed findings as to whether covid-19 has exacerbated child marriage or not. In the older cohort camp sample, 19% of girls worry about marrying earlier (compared to 11% of boys), yet at the same time older girls are twice as likely as older boys to say that the pressure to marry has decreased since covid-19. In the younger cohort, gender differences are far less pronounced with 6% of young girls reporting worries about marrying earlier compared to 5% of boys, and 14% of girls feeling that the pressure to marry has decreased compared to 11% of boys. This may highlight an unexpected protective effect of the pandemic for some adolescents that will be the topic of future research.

While not measuring adolescents' direct exposure to violence due to privacy concerns, data does suggest that married girls may be at a higher risk of GBV than their unmarried counterparts during the pandemic. For example, Rohingya and Bangladeshi married girls are more than twice as likely as unmarried girls to report that GBV has increased in the community during covid-19 (22% and 9% respectively).

Health and nutrition

Most Rohingya and Bangladeshi adolescents report their health to be good or very good (92% and 87% respectively). However, across locations 10% of our sample reported that their health had deteriorated after covid-19, with boys nearly twice as likely to report this as girls (12% and 7% respectively). Linked to this, 16% of the sample had had one covid-19-related symptom in the two weeks prior to the survey. While some adolescents claim that covid-19 patients need to visit the hospital *'[the] government said if someone has fever, cold and cough, then he/she should be taken to hospital'* (15-year-old boy, site 2), our key informant interviews demonstrate that this is not always the case. A site manager from

► At the beginning, [Rohingyas] used to say, “They will [need to] shoot us [before we go] to the isolation centres” and we saw that caseloads reduced ... They were afraid [that] either they would be kept in isolation for fever and cough, or they may catch Corona from the hospitals.’

(A site manager from site 3)

site 3 explained, ‘At the beginning, [Rohingyas] used to say, “They will [need to] shoot us [before we go] to the isolation centres” and we saw that caseloads reduced ... They were afraid [that] either they would be kept in isolation for fever and cough, or they may catch Corona from the hospitals. For these two reasons they came less.’ The same site manager also explained that after liaising extensively with camp focal points from the Rohingya community (Majhis) as well as religious and community leaders, they were able to dispense accurate information to the community and health care uptake subsequently increased.

Our qualitative data presents a mixed picture as to whether covid-19 has restricted health service uptake in the case of non-covid-19 pathologies or illness. A 17-year-old married mother stated, ‘Yes, the hospital is open. I take [my daughter] there. They give medicine,’ while others claimed: ‘We cannot go to the hospital if we are sick. Earlier we used to go to IOM Hospital, but now we are not allowed to go there. Now when someone goes there, they say that he/she has contracted the corona virus. That’s why people are not willing to go to the hospital’ (17-year-old boy, site 3). Findings from adolescents with disabilities underscore that certain vulnerabilities persist with or without covid-19 measures. An 18-year-old boy with a physical impairment expressed, ‘Everything is like before. I mostly lie around all day ... I am unable to walk so I don’t go out. I haven’t gone out from my house for about two years. If the NGO would have taken me to a hospital for treatment, it would be better. I am [sad about it]. There [are hospitals] but they don’t take us. They didn’t take [us before either]. They come only to talk with me.’

Our mixed-methods data highlights that food insecurity is one of the most severe and concerning impacts of covid-19. Nearly all of our qualitative interviews reported the decreased availability of food, both in terms of reduced rations – thus a reduction of selling in-kind aid for cash⁶ – and a reduction of food purchased, as a result of income loss. A 17-year-old boy in site 1 worried, ‘Having food is too hard now [because] we can’t work.’ Quantitative data shows that 21% of adolescents claimed they felt hungrier in the past four weeks as a result of covid-19, with Bangladeshi adolescents 27% more likely to report this compared to Rohingya adolescents (23% and 18% respectively). Gender differences were also stark. In the camps, girls are 63% more likely to report hunger due to covid-19 (22% compared to 14% of boys). Similarly, in host communities, girls are 51% more likely to report this (27% vs 18%). Turning to the qualitative data, a 17-year-old married girl



► Sometimes we have to eat rice only with salt. We could sell food and buy something for us before. But [now] they give us food like we are beggars.

(A 17-year-old married girl in site 1)

in site 1 recounts the changes felt in her household since covid-19, *'Sometimes we have to eat rice only with salt. We could sell food and buy something for us before. But [now] they give us food like we are beggars. The potatoes were 15/16 taka before. Now the price has risen up to 32/30 taka. They used to give eight eggs per person earlier. But now they give five eggs.'* Similarly, a 19-year-old married girl noted, *'They give us less rations now ... it's about one month that every food item has decreased,'* and a 15-year-old male said, *'[In the past] we could have three meals per day. But we struggle with having two meals now.'*

When looking at survey data gathered at the household level, 58% of households reported cutting back on food served to boys and/or girls. Moreover, households across both camp and host communities exhibit a high degree of food insecurity. On average, households have experienced at least one of three types of extreme food insecurity in the past four weeks: 49.5% report not having any food in the household because of a lack of resources, 17.2% report having at least one household member go to sleep at night hungry because there was not enough food and 3.7% report one household member going a whole day and night without eating anything at all because there was not enough food. With regards to meals that include protein, 87% of our adolescent respondents state that they are less likely to eat meals containing protein and while there are no significant differences by location, girls are more likely to report this than boys (92% compared to 82% of boys). A 15-year-old girl explained, *'We have no money so we cannot buy raw food items like vegetables, fish and meat. We can't eat fresh food.'*

Economic empowerment

Across the Bangladeshi and Rohingya sample, 10.3% were engaged in paid work prior to covid-19, with boys four times more likely to be working than girls (17% compared to 4% respectively). However, paid work has either stopped or decreased for 85% of the working sample, with 57% of the Bangladeshi sample reporting not having restarted work compared to 75% of Rohingya. Only 2% of our sample, nearly all males, has engaged in new work since covid-19.

Qualitative data showcases that the loss of paid work, either personal income or household-level, is a cause of worry for the majority of adolescents in our sample, as described by an 18-year-old boy in site 2: *'We could earn money then. Now we can't. My elder brother used to work [at MSF] ... now he can't ... Depression comes as we can't earn money now';* and echoed by a 15-year-old girl in site 1, *'The people who used to go out of the camp for work can't go now. Transports are off. As this is the month of Ramadan the problem has increased even more.'*

Psychosocial well-being

Across camp and host communities, only 3.1% of adolescents exhibit signs of moderate to severe depression, measured using the Patient Health Questionnaire-8 (PHQ-8).⁷ This number is extremely low compared to global data that suggests 10–20% of adolescents experience mental illness (WHO, 2019), and deserves further analysis.

Although moderate to severe depression as measured through the PHQ-9 is low, 78% of adolescents are highly or moderately worried and anxious about covid-19. A 17-year-old boy at site 1 expressed this fear: *'I can't go anywhere as I'm getting afraid [of catching the disease.] I can't move anywhere, I just sit inside the house. I used to go outside and gossip with friends ... now it's impossible to do so.'* The qualitative data also suggests that due to cultural mobility restrictions placed on females – primarily in camps – boys appear to be most impacted by lockdown orders, lamenting a loosening of friendships: *'I have to be alone all the time which makes me sad. I am losing myself for all these disturbances and troubles'* (15-year-old, site 2), and a felt lack of freedom to *'go everywhere'* (17-year-old-boy, site 1). In terms of friendships, host community adolescents are more able to maintain contact with their friends on mobile phones and by interacting with them online via social media. A 15-year-old girl from site 4 said, *'I haven't met them (friends) for many days ... [but] I talked to [them] via mobile phone.'*

Our data also highlights that adolescents are both receiving and giving less support, defined as helping with problems, chores or health needs, due to covid-19. In camps, Rohingya boys are 23 percentage points more likely than girls to report

▮ [The] government is doing this for our betterment.

(A 17-year-old married male in site 1)

receiving less support (60% vs 37%) and 17 percentage points more likely to report giving less support (52% vs 34%). Similarly, in host communities, Bangladeshi boys are 30 percentage points more likely to report receiving less support (62% vs 32%) and 22 percentage points more likely to report giving less support than girls (52% and 30%).

Many adolescents appear to find solace in prayer and in the resoluteness of Allah to decide the virus' course, wherever that will lead. A 15-year-old male in site 1 stated, *'How the virus will demolish is dependent on the order of Allah'*; a 15-year-old boy in site 2 said, *'Corona virus is the wrath of God'*; while a 17-year-old married girl explained, *'We are just living by the grace of Allah,'* and an 18-year-old boy living with a disability expressed, *'[Coronavirus] is from Allah. Allah does everything for the betterment of people, nothing to hamper us. If we pray he will give us rizik (sustenance). None but Allah can cure the disease, so pray to Allah. Everybody has to die one day. Let it be coronavirus if Allah wishes. No one can escape death.'* Echoing this, our quantitative survey found that 54% of adolescents agreed that God will protect them from covid-19.

How do adolescents view the government's response to the pandemic?

None of the Rohingya adolescents in our qualitative sample expressed negativity towards the government of Bangladesh's response to the pandemic and all agreed that although they were suffering from the stringent containment measures, they were enacted to protect them. *'[The] government is doing this for our betterment,'* (17-year-old male, site 1) and *'[the response] is good for us. We aren't infected. [But] we cannot go through life happily. Now I can't go to school. Before I went [to] learn tailoring. [Now] I can't go out, so I have to stay in home, can't learn the work. Before I have the income and at least I can manage the expenditure of daily shopping. But now I can't go out. I have no brother, no father, how will I manage? So [the government's actions are] good for the disease, but not good for our availability of food and our general well-being.'* (15-year-old-girl, site 1). Likewise, our quantitative data finds that adolescents believe that the lockdown policies are justified, with 94% of older adolescents believing that all shops should close during the pandemic and 84% believing that people should not participate in religious gatherings. In addition, few adolescents believe that the authorities' response to the pandemic is not sufficient, with only 13% of Bangladeshi adolescents and 6% of Rohingya adolescents reporting this.



Conclusions and policy and programming implications

Our findings have highlighted significantly heightened vulnerabilities facing adolescent girls and boys in both host communities and Rohingya refugee camps in Cox's Bazar in the context of the covid-19 pandemic. This evidence points to a number of priority policy and programming priorities in terms of the package of support young people in refugee and host communities need to weather the effects of the pandemic and foster their resilience:

- 1. Tackling food insecurity:** Notwithstanding the continuation of blanket food assistance to all Rohingya refugees in Cox's Bazar by the food security sector and additional targeting of host community residents, the increased food insecurity experienced by adolescents must be urgently addressed. The loss of purchasing power due to an interruption of income-generating activities, coupled with higher prices in the periodically open markets, has led to disruptions in dietary patterns and a decrease in food intake. *Food security sector partners* should urgently scale up and increase in-kind and voucher food support in the camps, and both food and cash support in host communities, informed by a detailed gender- and age-needs analysis.
- 2. Resuming education and training programmes:** Among adolescents, resuming school, vocational learning and income-generating skills training are pressing needs. Although the Ministry of Education called for an indefinite shutting of education institutions on 16 March 2020, a ban rightfully extending to learning centres in the camps, the Refugee Relief and Repatriation Commissioner's (RRRC) decision to define education as a non-essential activity in the camps further resulted in the restriction of UN and NGO education staff. Not only has this interrupted learning for all adolescents who were participating in education, but it has also severed social support systems and prevented the easy distribution of covid-19-related communication messaging. *Education sector partners* should bolster alternative, remote learning material and methodologies during the closure of learning and training centres to alleviate interruptions to learning. Tailored material should be directed to those adolescents who are not able to rely on caregiver support, due to widespread illiteracy among the Rohingya. This should be twinned with the prioritisation of WASH and other infrastructure to ensure that educational centres may safely reopen and continuous provision of covid-19 lifesaving messaging and psychosocial support. Finally, the *government of Bangladesh* alongside the *education cluster* should renew commitments and establish plans to implement the Myanmar curriculum pilot for grades 6–9 and the Skills Development Framework for Adolescents and Youth.
For Bangladeshi adolescents, the *government of Bangladesh* must continue scaling up remote teaching and learning disseminated via mobile phones, radio and television plus learning material distribution, which will be key to continue learning. Establishing a medium- to long-term recovery strategy to address the educational gaps created by the pandemic, including the development of a plan allowing for the safe reopening of schools, will best mitigate disruptions to learning.
- 3. Strengthening awareness-raising, reporting and mitigation of age- and gender-based protection risks during the pandemic:** For both Bangladeshi and Rohingya adolescents, humanitarian *protection sector actors* and their government counterparts must ensure that public communication messaging and home-based awareness sessions for adolescents and their families on age- and gender-based protection risks potentially exacerbated by covid-19 – including child marriage and child labour – reach all families. Robust reporting channels need to be established and maintained, including in-person options, phone and online hotlines, as well as provisioning made for legal and medical support for adolescents facing protection risks.
- 4. Addressing restrictions to digital connectivity in the camps to promote access to information and online learning:** Ongoing ICT restrictions in the camps has meant that Rohingya adolescents have little-to-no access to media sources, as well as being cut out of any type of distance learning. Rohingya groups are advocating against the ban as it is seen to exacerbate their vulnerabilities and marginalisation from the rest of the world, as well as render humanitarian coordination more complex – both inter-sector coordination and between humanitarian partners and Rohingya adolescents (ISCG et al., 2020). Although a lifting of the internet ban in set intervals of the day to alleviate information discontinuity and facilitate communication among the Rohingya and humanitarian partners has been agreed upon by the government of Bangladesh in principle, multisectoral coordination is further required for even implementation on the ground.

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Endnote

- 1 Suggested citation: Guglielmi, S., Seager, J., Mitu, K., Baird, S. and Jones, N. (2020) "People won't die due to the disease; they will die due to hunger": Exploring the impacts of covid-19 on Rohingya and Bangladeshi adolescents in Cox's Bazar. Policy brief. London: Gender and Adolescence: Global Evidence.

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- 2 The Cox's Bazar Panel Survey (CBPS) is a partnership between the Yale Macmillan Center Program on Refugees, Forced Displacement, and Humanitarian Responses (Yale Macmillan PRFDHR), the Gender and Adolescence: Global Evidence (GAGE) programme, and the Poverty and Equity Global Practice (GPVDR) of the World Bank.
- 3 Where the term 'adolescents' is used, it encompasses both adolescent girls and boys aged 10–19.
- 4 This local measurement unit considers the size of an adult man's elbow to fingertip, such that 1 hand = 1.5ft and 3 hands = 4.5ft.
- 5 Rohingya children and adolescents do not have access to formal education and access non-formal learning in predominately NGO and UN-run learning centres (Magee et al., 2020; UNICEF, 2020).
- 6 The practice of selling portions of in-kind assistance received by humanitarian partners, and/or items redeemed with vouchers in local markets in order to obtain cash occurs in the Rohingya context (UNHCR, 2018).
- 7 PHQ-8 is a modification of the PHQ-9 clinical diagnostic questionnaire that excludes the question about suicidal ideation. A score of 10 or higher characterises moderate to severe depression.